DOCUMENT RESUME

ED 303 294 RC 016 926

TITLE Poverty and Hunger in Hispanic America: The Inadequacy of Data for Policy Planning. Hearing before the Select Committee on Hunger. United States House of Representatives, One Hundredth Congress, Second Session (March 30, 1988).

INSTITUTION Congress of the U.S., Washington, DC. House Select Committee on Hunger.

PUB DATE 88

NOTE 179p.; Serial No. 100-24. Contains some small, light type.

AVAILABLE FROM Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.

PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01/PC08 Plus Postage.

DESCRIPTORS Federal Programs; Government Role; Health Programs; Health Services; Hearings; *Hispanic Americans; *Hunger; *Nutrition; Outreach Programs; *Poverty; Primary Sources

IDENTIFIERS Congress 100th

ABSTRACT

This hearing addresses issues of health, hunger, and malnutrition among Hispanic Americans. Health and poverty agency officials made statements before the committee and expressed difficulty in examining the health- and poverty-related problems among Hispanics because of a lack of data. Testimony indicated that previous data regarding the health of the Hispanic population had been inaccurate, and that part of the problem entailed definition of the term "Hispanic" itself. Testimony also reported that more federal money was being spent on Hispanic health and poverty problems than ever before. Members of Congress offered information about the need for better data and more health "outreach" to poor Hispanics in their districts. Private program recipients spoke directly about health problems among Hispanics. Their testimony generally addressed the inadequacies of federal health and poverty programs. Local officials indicated the need for national data collection on Hispanic health and nutrition. Among additional material appended is a General Accounting Office briefing report ("Health and Nutrition: Collection of Vital Statistical Data on Hispanics"); and material from the Texas Association of Community Action Agencies, Inc. ("Texas Hunger Facts"). (TES)

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POVERTY AND HUNGER IN HISPANIC AMERICA: THE INADEQUACY OF DATA FOR POLICY PLANNING

HEARING

BEFORE THE

SELECT COMMITTEE ON HUNGER HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MARCH 30, 1988

Serial No. 100-24

Printed for the use of the Select Committee on Hunger

RC 016926

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POVERTY AND HUNGER IN HISPANIC AMERICA: THE INADEQUACY OF DATA FOR POLICY PLANNING

WEDNESDAY, MARCH 30, 1988

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON HUNGER,
Washington, DC.

The committee met, pursuant to call, at 2 p.m., in room 2359A, Rayburn House Office Building, Hon. Mickey Leland [chairman of the committee] presiding.

Members present: Representatives Carr, Penny, and Gilman.

Also present: Representatives Richardson and Bustamante.

Chairman LELAND. We are going to start our hearing, and because of the tardiness of the Chair I am going to defer now to my good friend and colleague, Mr. Gilman, for his opening statement.

OPENING STATEMENT OF HON. BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. GILMAN. Thank you, Mr. Chairman, and I want to welcome our colleagues before us today.

I thank the gentleman for yielding, and, Mr. Chairman, I want to express my appreciation for your arranging this important hearing on poverty and hunger in the Hispanic community and the inadequacy of data for proper policy planning for the health needs of that community. It is, indeed, an important issue, a vital issue, that does require our committee's full attention.

Throughout our Nation, Hispanics and particularly Hispanic migrant workers are amongst the vulnerable of all Americans. They have low and unstable family incomes, difficult working conditions, poor to fairly poor living conditions. The transient nature of their lives and their families' lives, limited health and social services, have led to a great deal of health problems, lower life expectancy, and sometimes a lack of education leads to other problems throughout their lives.

Seasonal farm workers are sometimes better off but still are unemployed for a major portion of the year and have relatively little job security and often have difficulty in gaining access to many of our social programs.

The lack of health data amongst the Hispanic community makes it extremely difficult to develop helpful health planning. What are the consequences? That, I think, is an important issue for us to examine today, and I am particularly interested in learning from our colleagues: the gentleman from New Mexico, Mr. Richardson; the

gentleman from Texas, Mr. Bustamante; the family that will be with us; and from the service providers who have traveled here today to tell us about the accessibility of existing programs and the effectiveness of any Federal and private programs that have been designed to try to improve the living conditions of this vulnerable and often hidden population.

We welcome all of the witnesses who have been willing to share with us their research, their thoughts, and their suggestions, and we look forward to their testimony.

Thank you, Mr. Chairman.

OPENING STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Chairman LELAND. I thank the gentleman from New York.

Let me just proceed by saying that the Select Committee on Hunger has convened this hearing to assess the need for expanded data collection on the income, health, and nutritional status of Hispanics in the United States. Hispanics are currently the second largest minority group in this country. According to a March 1987 report issued by the Census Bureau last year, the Hispanic population reached about 18.8 million people, an increase of 30 percent since 1980.

In addressing the income status of the Hispanic population, the report indicates that they are disproportionately disadvantaged when compared to other Americans. In 1986, Hispanic families had an median income of $19,995, compared with $30,231 for non-Hispanic families. Of the Hispanic families 25 percent had incomes below the poverty level while 10 percent of non-Hispanic families lived in poverty.

Despite the growing population and the increasing number of Hispanics living in poverty, little is known about their health and nutritional status and their participation in public assistance programs. I remember very vividly when Mr. Califano was Secretary of the Department of Health, Education, and Welfare some time ago under the Carter administration, I had asked at a hearing at that time of the Health and Environment Subcommittee what was the infant mortality rate amongst Hispanics in this country, and he said that they do not collect data on the Hispanic community dealing with that issue, and I was really shocked to find out how insensitive that was, not necessarily on the personality of the Secretary but at least in terms of the lack of wisdom and sensitivity on the part of the administration during that time, and things have not gotten much better; as a matter of fact, there is one school of thought that would suggest that they have gotten worse.

Recently, I was joined by Congressmen Albert Bustamante and Tony Coelho in commissioning the GAO, the General Accounting Office, to conduct an examination of the methods through which data collection on the nutrition and health status of Hispanics could be improved and expanded. The GAO report, which we received on Monday, concludes that modest improvements have been made in the collection of data on Hispanics. Let us hope that is the case indeed. The study notes, however, that budget constraints have prevented the existing data collection systems from gathering

a large enough sampling of information to provide an overall assessment of the health and nutritional status of this select group that we deal with today.

If we are to be successful in implementing and maintaining a public assistance network which is responsive to low-income, at-risk Hispanics, we must know what their specific needs are. We have an impressive list of witnesses who will be able to provide us with the guidance as to what steps we can take to improve the availability of data on Hispanics and how we could utilize this information to more effectively provide them with services.

Let me apologize to my colleagues for my tardiness. Let me assure you that I had a very compelling issue to deal with for those 30 minutes that I was absent here, but I appreciate their patience and their understanding.

We have with us the Honorable Al Bustamante, a fellow Texan, and my good friend Bill Richardson from New Mexico.

Bienvenido, mis companeros.

Mr. GILMAN. Mr. Chairman, would you yield for just a moment before the witnesses proceed?

Chairman LELAND. I would be happy to yield to the gentleman from New York.

Mr. GILMAN. I would like to submit for the record an opening statement by the ranking minority member, Congressman Bill Emerson.

Chairman LELAND. Without objection, that opening statement will be placed in the appropriate section of this hearing.

Mr. GILMAN. Thank you, Mr. Chairman.

[The prepared statement of Mr. Emerson appears at the conclusion of the hearing, see p. 58.]

Mr. BUSTAMANTE. Mr. Chairman, let me yield to my friend and colleague, Mr. Richardson, because he has another appointment.

Chairman LELAND. The chairman is most delighted to learn that he does have a friend.

The gentleman from New Mexico.

STATEMENT OF HON. BILL RICHARDSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. RICHARDSON. Thank you very much, Mr. Chairman.

Let me first of all commend you and your select committee for holding this hearing which I believe is long overdue and commend you for your leadership in doing it. It is your committee, after all, that is doing this.

Let me commend Albert Bustamante for his chairmanship of the Hispanic Caucus and for, under his tenure, making this an important issue in the Hispanic Caucus legislative agenda.

One of the biggest problems, Mr. Chairman, is that this is an issue that is critical not just to southwestern States with large Hispanic populations but I think for the entire country. That is, what you and Mr. Gilman stated in your opening statement, a lack of health data on the Hispanic community specifically as it relates to Hispanics in the health professions. The quality of Hispanic health data in general is abysmal. We don't know the health status of the Hispanic community either in comparison to other segments of the

population or for different time frames. Without such information, health planning becomes impossible. Furthermore, we do a great disservice to this community.

The sample in the Health and Nutrition Examination Survey of 1982 provided us with a first picture of the health of the Hispanic community. However, for a number of reasons this sample only gave us a limited view of the health of the community. First, the sample did not compare Hispanics to other groups in the population. Second, because it was a one-time sample it did not and cannot provide a time continuum. Therefore, we cannot determine whether the Hispanic community's health is improving or worsening.

I am particularly concerned with the lack of data on the health needs. We don't know the extent or nature of our own health problems. We do not know the number of Hispanic doctors, nurses, or other allied health professionals or whether they are serving the Hispanic community or other communities. We frankly don't know what the Hispanic community needs nor who is filling that need.

As a result, I am introducing legislation in the Commerce Committee to address the need for health professionals to deliver appropriate care to the Hispanic community. One of the major limitations in preparing this legislation has been the lack of data concerning the health professional needs of the community. It has been especially difficult to determine the extent of the need for health professionals delivering culturally and linguistically appropriate care to the Hispanic community. The legislation not only seeks to increase the number of Hispanic physicians practicing in medically underserved community but also provides for an analysis of the health professional needs of the community.

It is my firm belief that the report to the President and the Congress on the status of health personnel in the United States, as mandated by section 708 of the Public Health Service Act, should contain this type of information so that health planners can evaluate the Hispanic community's current and projected need for health professionals and more effectively allocate existing health professional resources among Hispanic communities.

Such is not the case. The latest report issued in 1986 contains no information on the need for health professionals in the Hispanic communities by specialty or geographic location. The only information about Hispanics in this report is a minor inclusion on Hispanic enrollment in medical schools and schools of osteopathy and dentistry. My legislation would assure that critical information by both specialty and geographic location be included for Hispanics and for other minority groups.

Mr. Chairman, in closing, I am confident that this hearing will shed light on a very serious problem. For the record, Mr. Chairman, I want to give you some specific statistics when I talk about the lack of health profession practitioners in the Hispanic community and when I talk about population parity in terms of health professionals.

Despite the fact that Hispanics represent 7.9 percent of the American mainland population, they account for only about 4 percent of physicians and 2 percent of registered nurses. They are also underrepresented in allied or traditional health professions. His-

panics comprise 3.4 percent of health diagnosing practitioners, 2.4 percent of health assessment and treating practitioners, 3.8 percent of health technologists and technicians, 5.3 percent of health service occupations, and 4 percent of health technologists and assistants.

We also have a problem, Mr. Chairman, in terms of Hispanics in medical schools. In 1985, one-fifth of all medical schools in the United States had no Hispanics in their 1985 graduating class. Additionally, the percentage of Mexican American and mainland Puerto Ricans in medical schools' graduating classes has remained fairly constant at 1.5 and 0.6 percent. This is not occurring because Hispanics are not qualified. The acceptance rate of Hispanic medical school applicants is slightly higher than is the acceptance rate for all applicants: 56 and 55 percent, respectively.

Mr. Chairman, I want to submit for the record a number of statistics relating to my testimony, not just dealing with what I just discussed. I think it is important that we also look toward the future, at a policy in this country that deals with financing this as a positive investment for the Hispanic community. One key is to set up medical student scholarship programs but also, like the black community which has been a leader in many areas, because of its historically black colleges, that universities with significant numbers of Hispanics in their population be given access.

I know there have been some conflicts lately between the black and Hispanic communities. I think this should not be the case because we are all in this together. Through the leadership of Congressman Bustamante, my community is trying first of all, to do the most elemental of tasks; that is, to collect the data that we don't have. We don't know how big a problem it is. We have a serious problem, and then we need an initiative to correct the problem. Unfortunately, it takes money and in these days of budget constraints, that is not easy to ask for.

But if we are looking to addressing the needs of, as you said, the largest minority in this country by the year 2000, we have got to do a better job, and I am confident with your leadership, Mr. Gilman, Mr. Carr, and your excellent committee that we will make some major strides.

I thank you, and I thank the chairman for his courtesy in letting me testify.

[The prepared statement of Mr. Richardson appears at the conclusion of the hearing, see p. 60.]

Chairman LELAND. For the record, we will include for your purposes the extraneous material that you brought with you; we appreciate it.

[The material referred to above retained in committee files.]

Chairman LELAND. By the way, if I can make an editorial comment before the gentleman leaves, I certainly appreciate his leadership in this matter and also his support for not only the Hispanic community in his efforts to try to enhance the quality of life for Hispanic people but for all the people whom he has alluded to.

Mr. RICHARDSON. Thank you, Mr. Chairman.

Chairman LELAND. Thank you.

The chairman of the Congressional Hispanic Caucus, Mr. Bustamante.

STATEMENT OF HON. ALBERT G. BUSTAMANTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BUSTAMANTE. Thank you, Mr. Chairman, and Mr. Gilman, Mr. Carr, thank you so much for allowing me to appear before this committee on the health and nutrition of Hispanics.

Let me first take a brief moment to recognize several individuals and thank them for their contribution to this hearing. I would like to thank my constituents, the Cortez family of San Antonio, TX, for agreeing to share their life experiences with this committee. I wish to express my appreciation for Dr. Urby's submission of written testimony on Hispanic health and poverty. Dr. Urby is the director of El Carmen Clinic just outside the city of San Antonio. He took time out of his busy schedule to put into words his insights on the health problems of low-income Hispanic patients he treats daily in the San Antonio area. Also, I would like to thank Rose Valdez for her input into the overall situation of the Cortez family as their dedicated and knowledgeable social worker. Each of these individuals' testimony will assist this committee in gauging the severity of the problems we are here to address.

Let me start this discussion with a brief social profile of Hispanic Americans then proceed to explore prevalent health problems that exist in this environment. Most of the statistical information I will provide has been retrieved from two sources: one, the Task Force Report on Black and Minority Health of the Secretary of Health and Human Services; and, two, the Aging Society Project, Hispanics in an Aging Society.

In 1987, there were approximately 18.79 million Hispanics in the United States. Since 1970, the Hispanic population has grown by over 60 percent, contributing to 23 percent of the total growth of the U.S. population from 1970 to 1980. The Hispanic population is expected to continue this high rate of growth well into the end of this century.

Despite their increasing numbers, Hispanics have not benefited fully from medical advances made in the last 50 years. Today, minorities in the United States continue to experience a greater incidence of many diseases. According to the report on minority health, four social characteristics are believed to significantly influence minority health status in the United States today: one, demographic profiles; two, nutritional standards and dietary practices; three, environmental and occupational exposures; and, four, stress and coping patterns.

I would like to emphasize that there is a severe lack of data on minority health which may be due to several combined factors. The first factor is that there are no standard practices used by all the States for including ethnicity identifiers in reported data. Furthermore, Federal identifiers that are required by OMB were too general to permit delineation within subgroups. Even when a more specific breakdown of race and ethnicity is used, the information may eventually be lumped together as "other." This has minimal, if any, value to health researchers.

Another concern is that data collected from national surveys usually measure minorities in proportion to their presence in the

U.S. population. Therefore, the less numerous a minority group is, the less information there will be available on them.

There also exists an obvious lack of documentation on illegal workers resulting in a demographic barrier to a substantial portion of the Hispanic population. The aggregate result of this lack of information means greater difficulty in truly portraying the health status of the Hispanic population.

Hispanics experience a unique work situation and are exposed to more hazards in the work place than non-Hispanics. Generally, Hispanics work in operative and manufacturing occupations. Hispanics are overrepresented in these positions as well as farming and metal mining. These industries report the first and second greatest number of work-related injuries. Farming and metal mining are two additional high-risk employment areas. Data from the Social Security Administration reveal that severe disability resulting from work-related injuries was twice as high among Hispanics as among non-minority workers in 1980.

There may be questions as to why large numbers of Hispanics are concentrated in these jobs. One contributing factor may be the typical level of education a Hispanic receives. On the average, Mexican Americans complete only 9.8 school years. The National Center for Education Statistics reports a high drop-out rate of 18 percent for Hispanics, and in the large urban centers the drop-out rate is often found to be in the range between 50 and 70 percent.

Why is there such a disparity in education levels? One reason may be due to the typical size and income of Hispanic families. Mexican American families were found among the largest families, averaging 4.09 percent; 30 percent of all Hispanics were living below the official poverty level in 1982; and 13.8 percent were unemployed. Due to these typical large families and the small amount of income coming into the household for essentials, many youngsters decided that it is better for the family if they dropped out of school to help out financially.

Let me say to you, Mr. Chairman and my colleagues, that my experience as one who came from a migrant family that used to go to the Willamette Valley of Oregon every year in the 1950's, around 1950 we started out in my class in Asherton, TX, a small migrant community of South Texas, with a number of about 28 youngsters. When I finished high school, there were 13 of us. From 28 we dropped to 13. Many of us came from large families. I was the oldest of 11 children in my family. I don't think we, many of us, ever saw a doctor, much less a dentist, and the education that we received in many of these areas was substandard. It was not the teachers' fault; they did the best they could, and it was the best that we could afford in some of those small communities. So we had to struggle, and many of our brothers and sisters had to drop out of school. The need was too great to survive from day to day.

But it hasn't changed since 1950. We still have the same problem in many of these areas. In the San Antonio area as well as the rural areas of South Texas, or whether it be New Mexico, Arizona, or California, we still continue to experience almost the same conditions of 50-some-odd percent school drop-out rate in many areas, or of the area that I represent. So it is a real concern, and I share this experience with you because it was something that I had to

live on a daily basis. We weren't looking to the future, we were looking for survival on a day-to-day basis, and many of these families are experiencing the same type of experience that we experienced when I was in school.

It is generally accepted that without a high school diploma it is nearly impossible to obtain work which offers job security and earnings above minimum wage. This, in turn, fosters another generation of undereducated, underemployed Hispanics. A truly difficult life situation is being created here, one of stress and anger. This unique pattern of exposure to stress and the ways of dealing with stress may play a crucial role in Hispanic and minority health.

It is suggested that the ways an individual copes with stress and the resources available to resolve stressful situations play an important role in health outcome. In response to this stress and from what statistics are available, there is an indication that young Hispanics are turning to unhealthy means of coping. That is, there is an alarmingly high incidence of drug and alcohol abuse among young Hispanics.

It is suggested that not only stress prompts such behavior but also that Hispanics' unique socioeconomic situation plays a major role in this behavior. Most alarming is the use of intravenous drugs which has prompted yet another health concern. One recent and alarming health problem that stems from intravenous drug use by Hispanics is AIDS. Mr. Gilman, of course, is certainly aware of what is happening in areas like New York City where the Puerto Rican family and the Puerto Rican community have experienced a high incidence of these problems.

So Hispanics account for 14 percent of all reported cases of AIDS. This is largely because Hispanics constitute 10.8 percent of inner city populations. Urban areas have recorded a concentrated drug abuse problem indicating that Hispanics may be at a somewhat greater risk of drug abuse and its consequences, according to HHS reports.

The 1984 Drug Abuse Warning Network data also show that 42 percent of Hispanics, as compared with 40 percent of whites, administer cocaine by injection. This data is suggestive of the general tendency of Hispanic drug addicts toward intravenous drug abuse. Intravenous drug abuse through the sharing of dirty needles is one of the major forms of exposure to AIDS, which explains the high incidence of the disease among Hispanics.

Hispanics have a high incidence of diabetes. Although the disease is also prevalent among black Americans, Native Americans, and Pacific Asian Islanders, the most common form of diabetes among Hispanics is non-insulin-dependent diabetes, which represents 95 percent of all reported cases of the disease nationwide.

For that reason, when I mention the word "diabetes," I am specifically referring to non-insulin-dependent diabetes. Of all Hispanics, Mexican Americans are the most susceptible to diabetes with a rate three to five times higher than the general population. Among the complications arising from diabetes are amputations, blindness, kidney failure, heart disease, and stroke. By avoiding obesity, most Hispanics can prevent their contracting the disease. This, in turn,

will prevent them from suffering those other more severe complications, such as heart strokes.

In response to this problem, I have introduced H.R. 3259, the Diabetes Prevention Act of 1987. This bill is intended to reduce the prevalence of diabetes among minority populations at special risk.

I would like to conclude my remarks with a few recommendations. My first recommendation is for acquiring more data on Hispanic health. Without such additional information any health programs we design will be as effective as throwing darts into a dark room that may not even contain the bull's eye. That is why I believe it is essential for State and Federal health agencies to include more specific Hispanic identifiers on reported Government documents that are the primary source of demographic data for health researchers.

Second, we need to design community-based health education programs that are both bilingual and bicultural. Such programs need to be sensitive to the special needs and cultural values of the Hispanic community. To accomplish this end, we must increase recruitment of minority health professionals as, of course, my colleague Bill Richardson stated, who can depend on their own personal experience to formulate and implement culturally sensitive health education programs.

Such programs should utilize multi-media approaches to convey preventive education messages. This type of approach could be used successfully to combat diseases such as AIDS and diabetes whose high rate of incidence can be reduced through preventive education.

These types of programs could be modeled after the successful public service announcements that nonprofit organizations have utilized to combat heart disease and hypertension. This multimedia approach would be especially helpful to Federal health agencies to publicize the wealth of information they already have on many chronic diseases.

But woe is me in suggesting that the Federal bureaucracy become innovative. That is like asking a roving elephant to tiptoe through the tulips, and yet that is exactly what we must do to close the gap between the health status of Hispanics and the general population.

Another important element to bear in mind in health education is the role that cultural conflict plays as a contributing factor on Hispanic health. There is strong evidence to suggest that the conflict between Anglo American society and Hispanic cultural values has a devastating effect on the ability of Hispanics to cope with stress. In fact, studies have shown that the difficulty which Hispanics experience in resolving the cultural clash of their Hispanic heritage contributes heavily to the number of Hispanics engaged in alcohol and drug abuse.

Health education programs targeting the Hispanic population should include interviews with doctors, dietitians and other health care professionals. It would also be helpful to have testimonials from role models and community leaders who have taken the recommended steps to safeguard their health. Such programs should inform Hispanics of what chronic diseases they are at special risk to contract or what diagnostic tests they can request their doctor to

perform and of what steps to take in case they are diagnosed with a particular chronic disease. But I must emphasize again that all of these efforts are for naught if we do not endeavor to increase the data base on the Hispanic population.

I believe you have assisted us in realizing that goal, Mr. Chairman, by requesting the General Accounting Office to survey available data on Hispanic nutrition and health. I hope to continue working with you in the future to address these concerns.

Thank you very much.

[The prepared statement of Mr. Bustamante appears at the conclusion of the hearing, see p. 61.]

Chairman LELAND. I thank the chairman of the Hispanic Congressional Caucus. Thank you for your leadership on this issue. I, for one, will certainly work as closely as you would like on this issue. I have for years been very interested in trying to find out why is it that Hispanics have been so invisible in this country. Certainly, in the area of health it is unforgivable that we have not looked into this problem to the extent that we should have.

Mr. BUSTAMANTE. I thank the chairman, and of course I know of your record at the State level when you were at the State legislature, and you certainly have always expressed your concerns in many of these areas, and for that we are very grateful.

Chairman LELAND. Thank you.

Any comments or questions from my colleagues here?

Mr. Gilman.

Mr. GILMAN. Mr. Chairman, I wanted to thank the gentleman from Texas for his comprehensive statement. He certainly has outlined all of the problems involved in this.

Do you have any recommendations for improving outreach? That seems to be one of the major problems in all of our health programs.

Mr. BUSTAMANTE. I guess one of the recommendations that I have made would be in trying to bring informational programs, you know, as a means of outreach on preventive health care in many of these areas.

I go back to my own experience. It is a matter of economics. In my district, for instance, although I have part of San Antonio, when you look at the rest of the district the average income is around $5,000 per year. When you have to deal with that, you are dealing with really tough economics. It is one of the poorest districts in the United States, and it is difficult.

We always used to go to Oregon in mid-March and come back in September, and we worked the hops and the strawberries and the beans and what-have-you, but it would take away 5 months out of the year to work and try to accumulate enough for us to try to live the rest of the time in Texas. So it was just a constant vicious cycle, and many of these families are still doing the same thing, except that their work has diminished in many of these areas. There is not any work in many of these areas of South Texas.

Even in San Antonio, with a fast growing economic agenda that we have in that area, the average income per household is about $15,000. A lot of the new jobs that are being created are fairly good jobs, but they pay barely above the minimum wage. We are trying to diversify in the area of jobs so that we can attract better jobs for

our people, but it is tough to do that, especially in the southern end of my district. But it is not only true of my district; as the chairman well knows, it is true in Mr. de la Garza's district, it is true in El Paso, in Ron Coleman's district, it is true in my friend Solomon Ortiz's district; all of these areas have the same problem.

Mr. GILMAN. In our rural area of New York State, a part of which I represent, we have a very heavy vegetable growing area, and we have Hispanic migrant workers come to that area to help with the harvesting. There is a good regional farm workers' health center there. One of the big problems, of course, is to make information available of what is available at these health centers and to make the workers knowledgeable about what programs are available to them.

Mr. BUSTAMANTE. We have some of those programs in the South Texas area. I was on the COG, Council of Governments, and I was chairman of the Alamo Area Council of Governments that included a lot of our rural areas. It was an 11-county area. When I was chairman of the COG, of course, we stressed those types of programs.

I will give you an example. In the Crystal City area we have a clinic there that does a very, very good job. But they have resources that they get from the Ford Foundation, from different foundations. They have got to constantly be out there trying to find money in order to keep that clinic running, and it is a real tough thing to do, to try to get sufficient amounts of money to provide information and to provide health care for the very, very poor of our communities, the underserved, people that would never be served. As I said, in my family, if we saw a doctor five times, it was just too many times, for the whole family.

But it is a way of life, and I think that people like you certainly can change it, and Senator Bentsen has pledged his support to try to do something about this in many of these areas, so I am hopeful that we will put together a program that will be helpful.

Mr. GILMAN. Mr. Bustamante, have you reviewed the GAO report on collection of vital statistical data on Hispanics? I believe that that is dated March of 1988.

Mr. BUSTAMANTE. I have been briefed by staff.

Mr. GILMAN. Are you satisfied that there is some progress being made?

Mr. BUSTAMANTE. There is some progress being made, but we still have a long way to go.

Mr. GILMAN. Do you have any recommendations about specific things we can urge Congress——

Mr. BUSTAMANTE. Well, I hope that in the next census we can accumulate a lot of these data.

Mr. GILMAN. I would urge that you make some of those recommendations to the committee that both the chairman and I serve on, the Post Office and Civil Service Committee that has a subcommittee on the census. I think this would be an appropriate time now for making this.

Mr. BUSTAMANTE. We have been meeting with the representatives of the Census Office and with some of your committee members.

Mr. GILMAN. Thank you.

Thank you, Mr. Chairman.

Chairman LELAND. I thank the gentleman from New York.

The gentleman from Michigan.

Mr. CARR. Thank you.

It is good to see you. I want to thank you for your statement.

I have just a couple of questions that are really based in, I guess, ignorance on my part, and I would like maybe for you to help me with them. If you are not the person to ask, maybe one of the other witnesses can tell me.

I was reading the sheet that the committee had put out here about some demographics on Hispanic populations, and then I was trying to reflect on my own district in Pontiac, Michigan. What is the U.S. Census Bureau definition of a Hispanic person?

Mr. BUSTAMANTE. I think that we have increased the scope of that, hopefully, in which they will identify the major groups, whether it be the Mexican American, the Puerto Rican, the Cuban, the Colombians, the Central Americans—you know, Central America includes the five countries in Central America—Mexico—and get the definition of a Hispanic.

Let me tell you the story. Of course, I have grown with that one. In South Texas, in the 1930's—and I was born in the 1930's—we were simply Mexicans. Then in the 1940's, we got a new name, Latin Americans. Then in the 1950's, we became Mexican Americans. Then in the 1960's, we became Chicanos. Then in the 1970's, we became the Hispanics. So I have been through all these changes, and I hope the Census finally puts us all together, the different groups that can be identified as Hispanics.

So I don't mind which group, as long as there is a count, because I think it serves a purpose, especially from such a group as this group, a very mobile group, a group that, like I said, lives sometimes—a lot of the people in that community live from day to day.

Mr. CARR. On my staff, for example, I have a woman whose father is a Hispanic, both of his parents were Hispanics, and her mother is not a Hispanic. Under the Census Bureau definition, what is she?

Mr. BUSTAMANTE. A Hispanic.

Mr. CARR. She is a Hispanic.

Mr. BUSTAMANTE. It is like asking me what my children are. I married an Anglo-Saxon woman, and my children are Bustamantes.

Chairman LELAND. If the gentleman would yield, what about Bill Richardson?

Mr. BUSTAMANTE. He is a real Mexican, because his mother was from Mexico, and his father was also from Mexico with the name Richardson.

We will live it up to the discretion of those who count, hopefully that there will not be an undercount. You know, there is information to the fact that we were undercounted by about 5 percent. I think that the Census Bureau, with all the preparation that they have availed themselves to, they will do a lot better job this time around than the last time.

Mr. CARR. Well, we would hope so, because we rely on the data base that they supply.

Coming back to my question, suppose an individual has only one of four grandparents who is a Hispanic, is that person then a Hispanic?

Mr. BUSTAMANTE. Probably not.

Mr. CARR. Probably not.

Mr. BUSTAMANTE. It depends on the individual, like I said. I don't know whom that individual identifies with. Suppose it is a Martinez, you know. Well, is Billy Martinez Tauzin a Hispanic or a Cajun from Louisiana?

Chairman LELAND. Or is he black?

Mr. BUSTAMANTE. Yes.

Chairman LELAND. Because if he is Cajun, he has got black blood in him.

Mr. BUSTAMANTE. We don't count Billy as a Tauzin. His name is Billy Martinez Tauzin. So it shouldn't be that difficult a problem.

Mr. CARR. I don't know that it is a problem. I am just trying to educate myself here.

Mr. BUSTAMANTE. I understand. Well, next time you see Billy, tell him, "I didn't know you were Hispanic."

Mr. CARR. Yes, you never know.

I guess my question goes to the fact that we do get Census data that says there are so many Hispanics, and I want to know in my own mind what are we talking about. Are we talking about people who are commonly regarded to be 100 percent Hispanic, or are they 10 percent Hispanic but the Hispanic surname seems to have survived, or are they from Spanish-speaking countries and maybe black?

Mr. BUSTAMANTE. It depends on what that individual wants to identify with. They are the ones that are going to be filling in the form or answering the question. Either he wants to or she wants to, or they are going to say, you know, "I'm not."

Mr. CARR. But isn't it a little more than just that? because the Census Bureau begins to make then some assumptions, and then they do estimates.

Mr. BUSTAMANTE. I can assure that there won't be that many problems in the Hispanic area.

Chairman LELAND. If the gentleman will yield, let me pursue this.

Mr. CARR. Yes.

Chairman LELAND. I think I realize the dilemma that the gentleman from Michigan has, and he has created it for me now; I thought it was very simple. Is it not true that, for the most part, an Hispanic is a person considered by the agencies of the Government a person who has an Hispanic surname, first and foremost?

Mr. BUSTAMANTE. Yes. The Bureau does not classify. They do not want to determine who an individual identifies with. They just collect the information; they ask the questions. If that individual says he or she is a Hispanic, they put them down as such.

Chairman LELAND. Let me ask you something, if I can ask the gentleman to yield further. If I decided—and maybe you are the wrong person to ask, Albert, but I guess am I asking it rhetorically—if I decide that, because of the color of my eyes and the color of my skin, that I am a white boy——

Mr. BUSTAMANTE. Well, I wouldn't say a white boy.

Chairman LELAND. Well, I mean, but I might decide I want to be a white boy.

Mr. BUSTAMANTE. OK.

Chairman LELAND. It is obviously better in America to be a white boy. Pardon that trite—not you, Bob, because I realize how hard it is.

Are you speaking for Richard Gephardt? Al Gore? He said, "Unless you are running for President." Dukakis is not doing so bad, but maybe you have to be ethnic.

Mr. BUSTAMANTE. He told me he was a Mexican in South Texas. [Laughter.]

Chairman LELAND. Es importante.

Mr. BUSTAMANTE. You too, you see, you could pass for a Hispanic.

Chairman LELAND. Maybe I should run for President, like Billy Tauzin, who is a little bit of everything; so am I. Maybe we should enter a new category called Calico.

The concern that I express at this time, is there a standard established where one is considered to be an Hispanic at some point, or is not, for that matter? I remember a court case in Louisiana where a lady had a one-sixteenth something black blood in her, and she challenged that she should not be considered black. I think she lost the case. Can you imagine walking about being white all your life, and somebody tells you you're black? Trouble in America.

Mr. BUSTAMANTE. Mr. Mendoza was—the health statistics—will also give testimony in relation to this.

Chairman LELAND. I yield back to the gentleman.

Mr. CARR. I don't ask the questions to try to be vexatious to the hearing.

Mr. BUSTAMANTE. I understand.

Mr. CARR. It's only when the committee gets presented with statistics about so many percent of Hispanics this and so many percent of Hispanics that, it seems to me then when you ask the follow-up question in the context of that statistic, who are you talking about?

Then to say that well, it's whatever anybody thinks of themselves, I mean, either the statistics have some reliability or we're talking about something else.

Mr. BUSTAMANTE. No, they will. If I was taking a census in New Mexico and you have Bill Richardson, what would my first thoughts be? You know, "Bill Richardson". Hispanic? You kidding me? You know, I always thought "Rodriquez, Martinez, Jimenez," those were the ones that—you know, but Bill Richardson, a real Mexican-American? And his line comes out of Mexico, about second generation. So you have to make that determination there according to what he gives you as information, and then it's what he believes he is.

Chairman LELAND. Except when you look at it.

Mr. BUSTAMANTE. That's right.

Mr. CARR. Well, maybe some of the other witnesses can help my education as to when we look at these statistics.

Mr. BUSTAMANTE. Those of us in the South have a greater southern accent.

Mr. CARR. I might say that I think, to some extent, in the south, it is possible that you have an idea of what an Hispanic is, that may not transport to a place like Michigan. If there are problems in my own district in Hispanic communities, the problems there may be further hidden because Hispanics in Michigan may be further hidden than they are.

I think it is purposeful to get something on the record somewhere, as long as we're talking about these statistics.

Mr. BUSTAMANTE. I don't know about the numbers in your district. What are the numbers in your district, 1 percent, less than 1 percent?

Mr. CARR. Well, the Census says there are about 3 percent, but it would seem to me that in the Michigan experience, where people have—I think the history fairly is that we have a large fruit growing industry there, and a lot of Hispanics have migrated to Michigan as migrant workers——

Mr. BUSTAMANTE. And stayed.

Mr. CARR [continuing]. And stayed as automobile workers.

Mr. BUSTAMANTE. Some of my family members stayed there.

Mr. CARR. And we're now into third and fourth generations where there has been a good deal of transplantation and marriage——

Mr. BUSTAMANTE. Culturation and all this good stuff.

Mr. CARR. Yeah. Now, the Hispanics in my community retain their cultural heritage and do it very well. Nonetheless, I think we're beginning to see that there is some dilution there——

Mr. BUSTAMANTE. Very little.

Mr. CARR. There might be a dilution of some Hispanic ancestry, but some of the problems still remain.

Mr. BUSTAMANTE. You know, I was surprised the other day when we were going over some of the statistics, I always thought San Antonio had a tremendous Hispanic population. But the city of Chicago has more Hispanics than San Antonio. That was surprising to me.

Mr. CARR. Well, I don't mean to delay the hearing. I just wanted to see if I could learn something.

Mr. BUSTAMANTE. I appreciate it.

Mr. Chairman, thank you so much.

Chairman LELAND. Thank you very much. Let's work closer together on these issues.

Mr. BUSTAMANTE. We will.

Chairman LELAND. I thank the gentleman from Texas.

The second panel we will ask to come forward is the Honorable John Bode, who is Assistant Secretary for Food and Consumer Services, U.S. Department of Agriculture, and Dr. Manning Feinleib, Director of the National Center for Health Statistics, Centers for Disease Control. Maybe you can help us with these definitions and we certainly appreciate your presence here and your contribution.

Mr. Secretary, will you proceed first, if you don't mind. And let me thank you for your continued collaboration and contributions to this committee.

STATEMENT OF JOHN W. BODE, ASSISTANT SECRETARY, FOOD AND CONSUMER SERVICES, U.S. DEPARTMENT OF AGRICULTURE

Mr. BODE. Thank you, Mr. Chairman. It's a pleasure to work with this committee and it's a pleasure to be here today.

With your permission, I will summarize my testimony so that I can more quickly move to try to answer any questions that you have.

Chairman LELAND. Not only with my permission, but with my great delight.

Mr. BODE. In my testimony there is a discussion of our budget proposals for this year. I believe it's fair to summarize that the President's budget submissions for food assistance programs are consistent with the bipartisan budget agreement and, as a result, it's the highest funding request in history for the food assistance programs of the Department of Agriculture.

The fact that the Food Stamp Program is our first line of defense against hunger in this country makes food stamps an especially important issue. Food stamp benefit amounts are based on household size, income, and assets. Benefits received vary according to income and household size. Our most current data, 1985, show that almost 11 percent of all households participating in the Food Stamp Program are Hispanic. Moreover, low-income Hispanics appear to make the same use of the Food Stamp Program as other low-income groups. Although poverty status is certainly not synonymous with food stamp eligibility, in 1985 households of Spanish origins comprised 11.4 percent of all poor households and were 14 percent of the poor households who reported food stamp receipt.

There are a number of aspects of the Food Stamp Program that assist non-English speaking individuals to participate in the Food Stamp Program. I will simply defer to the itemization of those in my testimony and move on to the Child Nutrition Programs.

In general, funding for Hispanics in the Child Nutrition Programs has increased steadily since fiscal year 1980, from 18.6 to 21.3 percent of all funding in these programs. In particular, funding to Hispanics in the National School Lunch Program and the School Breakfast Program has increased from $646 million in 1980 to $884 million in 1987. It is significant to note that although Hispanics comprise approximately 8 percent of all children in schools with these two programs, they receive approximately 21 percent of all Federal funding in these programs.

In the WIC Program, the $1.8 billion Special Supplemental Food Program for Women, Infants and Children, overall Hispanic participation has grown from 18.9 percent in fiscal year 1980 to 20.1 percent in fiscal year 1986 of all participation. This constitutes, of course, a fairly large percentage of total WIC participation, indicating a good utilization of the WIC Program by Hispanics.

I should also note that I share the concern expressed by you, Mr. Chairman, and others that have spoken already about our adequacy of data. I am pleased to report that improvements are being made in the National Nutrition Monitoring System, although we still have a ways to go. Improvements in particular are coming on line with improved data on the nutritional intakes of Hispanics in the United States, presently being gathered in the field, as part of

the nationwide food consumption survey. We are gathering data on food intakes, food consumption by Hispanics, and Hispanic data will be yielded through another part of the nutrition monitoring system, in the continuing survey of the food intakes of individuals, though because of sample size, as GAO indicated, it will take a while before that information will be in and available. It will be part of some of the data available from our rolling average approach to gathering data and analyzing it in the continuing survey of the food intakes of individuals.

We have a commitment to provide assistance to all low-income Americans, access to food assistance programs, and I believe that this commitment is generally being met. We can always make improvements and are pleased to work with this committee in efforts to do so.

Thank you, sir.

[The prepared statement of Mr. Bode appears at the conclusion of the hearing, see p. 102.]

Chairman LELAND. Thank you, Mr. Secretary.

Dr. Feinleib.

STATEMENT OF MANNING FEINLEIB, M.D., DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. FEINLEIB. It is a pleasure being here this afternoon. I really appreciate this opportunity.

I have prepared some written comments for the record, and I understand the committee has also received a recent report from GAO describing most of our system. I have some verbal comments I would like to make, if you wish, but I would like to ask your direction on whether we should proceed with my prepared statement or continue the interesting discussion we just had.

Chairman LELAND. Let me promise you, Doctor, that the full text of your comments, without objection, are entered into the record. They will be reviewed by our committee and staff. We would appreciate it, however, if you would just summarize and comment in any fashion that you so desire.

Dr. FEINLEIB. OK. I'll do it very briefly, then, to point out that NCHS, which is part of the Centers for Disease Control, is the Nation's principal health statistical agency. We carry on a broad program to collect statistical information on the health of the population and try to focus on special subgroups that have special health problems, including Hispanics.

To do this, we carry out a variety of programs, including the National Health and Nutrition Examination Survey, the National Health Interview Survey, and the Vital Statistics Cooperative Program. Since we already have on record a description of these systems, I thought I would spend just a few minutes highlighting some of the data to illustrate the scope of information that we are obtaining.

First of all, I would like to point out some of the health characteristics relative to maternal and infant health, which are the most sensitive and universally recognized indicators of health status.

About 11 percent of all births in the United States are to Hispanic mothers. Fertility rates of Hispanics are considerably higher than for either whites or blacks, making Hispanics the fastest growing ethnic group in the United States, even without considering the effects of immigration.

Teenage births are relatively common among Hispanics, and significant proportions of births to Mexican-Americans and Puerto Ricans are to unmarried women. These groups also receive considerably less early prenatal care than the rest of the population.

However, despite these disadvantages, Mexican-Americans do not appear to differ significantly from whites in birth outcome. Low birth weight and infant mortality are just about as common among the Hispanics as they are among the white population.

Chairman LELAND. Doctor, if you can, at that point, if you don't mind my interrupting, that is versus the problems seen in black——

Dr. FEINLEIB. That's correct. Of all the ethnic groups that we identify, the blacks are the ones that show the most adverse effects of low birth weight and infant mortality. That's correct.

In 1982 to 1984, as part of the Hispanic health and nutrition examination survey, we performed direct physical examinations of approximately 5,000 Hispanic children. Among our findings were the following:

The prevalence of low height for age—stunting, if you will—and low weight for height, wasting, these do not differ from that observed for whites or blacks. This provides some reassurance that there is no widespread problem of malnutrition among Hispanic children.

Hispanic children, though, may have inadequate intakes of vitamin A, but our research indicates that this is probably more attributable to poverty status rather than to any factors related to ethicity, per se.

Mexican-American children, like black children, were found to be more likely to have impaired vision than white children, but their hearing ability was about the same as white children.

Mexican-Americans had more decayed teeth and fewer filled teeth than white children. The immunization levels were fairly complete compared to any of the standards.

In the aggregate, Hispanics do not appear to differ dramatically from non-Hispanics in self-reported levels of illness or disability. In fact, when poverty status and age are taken into account, Hispanics are less likely to suffer from acute health conditions, they are less likely to be injured, and they are less likely to be limited in activity due to chronic health conditions.

A number of interesting observations can be made about the health risk factors of Hispanics. About the same proportion of Hispanic men smoke as do non-Hispanic men, but the Hispanic men tend to smoke fewer cigarettes. Hispanic women smoke less frequently than do non-Hispanic women, and they also tend to smoke less during pregnancy.

Obesity appears to be a major health problem among Mexican-American and Puerto Rican women. Serum cholesterol levels of Hispanics tend to be lower than for either whites or blacks.

The clearest difference between Hispanics and non-Hispanics is in the use of medical care and preventive services. Regardless of age or poverty status, Hispanics are less likely to see a physician or dentist, or to be hospitalized, than are whites. They are less likely to receive routine preventive care. For example, they are less likely to have breast examinations or Pap smears, or have their blood pressure checked. We find differences among Hispanic groups, with Puerto Ricans and Cuban Americans tending to use health services more frequently than Mexican-Americans.

These findings present clear challenges for health care providers. Our survey data indicates that the main difference may be in health insurance coverage, which may partially account for the lower use of health services.

Finally, the leading causes of death among Hispanics are heart disease, cancer, accidents, stroke, and homicide. Since the Hispanic population is comparatively younger, the chronic diseases like heart disease and cancer account for a small proportion of their death rates than for the general population. Even taking into account the younger average age of the Hispanic population, homicide plays a far greater role as a leading cause of death among Hispanics than among whites, ranking as the fifth leading cause among Hispanics, as it is among the black population.

Today's hearing has provided us an opportunity to review our accomplishments in improving data on Hispanic health over the last several years. I am encouraged by the progress we have been making. We now include Hispanic identifiers in our mortality data, and these are being published regularly.

We have already released 10 public use data tapes from the Hispanic Health and Nutrition Examination Survey, and we have the final 8 tapes currently being produced.

We are working with the various States to make sure that Hispanic identifiers are put on the birth certificate in the States where it is not currently used.

We are taking steps now to complete the design phase and the fielding testing phase for the third National Health and Nutrition Examination Survey which will update data on Mexican-Americans obtained as part of this special study of Hispanics.

Finally, the National Center for Health Services Research is currently conducting the 1987 National Medical Expenditures Survey, in which they are oversampling Hispanics, and this will allow further investigation of differences between Hispanics and non-Hispanics in the use of health care services.

Obviously, there are still several gaps in our information about Hispanics, but I am pleased that we are making progress in trying to close these gaps, and we will work toward a complete coverage of the Hispanic population.

Thank you. I will be happy to respond to any questions you may have.

[The prepared statement of Dr. Feinleib appears at the conclusion of the hearing, see p. 113.]

Chairman LELAND. Thank you, Dr. Feinleib. I appreciate your contribution here.

Let me commend you for the way that you have portioned out the data in regards to breaking down the different Hispanic catego-

ries. As a matter of fact, I was going to ask Mr. Bustamante, and I'm glad that you clarified to me that that is being done.

I presume that's a universal practice and not just for your agency, but with agencies across the board; is that correct?

Dr. FEINLEIB. It probably differs from agency to agency, but many of them ask first of the respondents if they are Hispanic and, if so, how they identify themselves within the Hispanic community.

Chairman LELAND. Let me pursue that just a little more.

Do you make determinations—and I presume you have to, given the problems that arise in gathering the kind of statistical data that you need—that you do analyze the different categories or the different groups within the Hispanic umbrella in accordance with socio-economic levels; is that correct?

Dr. FEINLEIB. Yes.

Chairman LELAND. Is there any given Hispanic group of people that is "better off" economically than any other group?

Dr. FEINLEIB. Yes. The Cuban-Americans tend to be better off than the other populations, probably with the Mexican-Americans being at the low end of the economic spectrum.

Chairman LELAND. Mexican-Americans are at the low end. That's when you are considering primarily three different groups——

Dr. FEINLEIB. That's right.

Chairman LELAND. Mexican-Americans, Puerto Ricans, and Cubans?

Dr. FEINLEIB. That's correct.

Chairman LELAND. I presume we don't have a predominance of other Hispanic Americans in this country. I know that there's a great influx of Guatemalans and Hondurans and other folks from Central and South America, but the predominant groups are Puerto Rican, Mexican-Americans and Cubans.

Dr. FEINLEIB. That's correct. And as you have in one of the press releases here, 63 percent of the Hispanic population are Mexican-Americans——

Chairman LELAND. Sixty-three percent.

Dr. FEINLEIB. Sixty-three percent, and 12 percent are Puerto Rican Americans, 5 percent Cuban, and the other 19 percent represent all the other nationalities of origin.

If I could just put this into perspective, the Hispanics represent almost 8 percent of the population, and about 6 percent of the total population are Mexican-Americans, with about 1 percent being Puerto Ricans, and less than one-half of 1 percent Cubans.

Chairman LELAND. Let me ask you something, then. The Cuban population represents 5 percent of the Hispanic group. If I was looking at the category of Hispanics in the socioeconomic statistical data, and I didn't break the different groups down into Puerto Rican, Mexican-American, and Cuban, to what extent does that 5 percent, being that it is better off economically than the other groups, distort the reality of the problems within the Hispanic umbrella?

Dr. FEINLEIB. That's a very complex question to answer. It depends, I think, a lot upon the condition you're looking at, whether or not economic level and also how well the sample has been designed to reflect the different proportions of the population in the

sample. I don't think I could give you a simple rule as to how much the effect might be. It would depend upon the conditions being——

Chairman LELAND. Do you think there is a need to be that meticulously analytical?

Dr. FEINLEIB. If the resources are available to get that kind of data and analyze it appropriately, it could be——

Chairman LELAND. What do you mean if the resources are available?

Dr. FEINLEIB. Well, for example, to conduct a survey where you get adequate numbers from each of the subgroups you're interested in, it requires getting a large enough sample from that subgroup. That's where the resource question comes in.

Chairman LELAND. As I indicated earlier, I was very disturbed when I first got to Congress to find that there was no real knowledge or information dealing with the problems of infant mortality in the Hispanic community, even though we have recently found out that it is now relatively the same as the white community. It still represented somewhat of an insensitivity on the part of the government or those who gather data on this information.

Don't you think it's necessary for us to pursue getting as much of this information as possible?

Dr. FEINLEIB. Absolutely. When you're dealing with records like vital statistics records, which are under the purview of the State—it's a State responsibility, not a Federal responsibility—the Federal offices provide guidelines, recommendations, or standards, if you will, and this is what we've been very active in doing.

On the other hand, the States decide whether or not to include items like that, and then it is the informants, the ones who fill out these—who provide the information and fill out this certificate, to make sure the information is put there and entered properly—that has been, as the earlier discussion emphasized, a bit of a problem in many cases.

Chairman LELAND. But by strong implication, you need more money for us to gather the kind of information that we need?

Dr. FEINLEIB. Well, I will just say that information doesn't come free.

Chairman LELAND. I hear you loud and clear.

Now, it is not your responsibility to answer why these problems exist. It is your responsibility to gather the information.

Dr. FEINLEIB. That's correct.

Chairman LELAND. Mr. Bode, on the other hand, it is your responsibility to make sure that these people are served in various and sundry ways; isn't that correct?

Mr. BODE. Yes, sir.

Chairman LELAND. Let me pursue a line of questioning with you, Mr. Bode.

What is the Department's position on creating outreach programs to encourage participation in food stamp assistance?

Mr. BODE. We feel that to require States to undertake food stamp outreach activities is inappropriate because they have not been shown to be effective. We have a very high level of participation in the Food Stamp Program when one looks at the number of people participating over the course of a year. About one out of every seven Americans has been receiving food stamps. The Food Stamp

Program is well known and participation is proportionately at levels that one would expect for the Hispanic population. There is not, in our view, evidence of underutilization of the Food Stamp Program among Hispanics or among other groups.

That is not, of course, intended to reflect an animus toward outreach but an animus toward the requirement that States undertake it. The Department of Agriculture does support States being free to encourage participation in the Food Stamp Program, even though the program is paid for exclusively by the Federal Government.

Chairman LELAND. Mr. Bode, I hear you and I understand what you're saying. I don't necessarily agree with where you're coming from. Obviously, I don't agree, and you know that very well.

Mr. BODE. I understand, sir.

Chairman LELAND. But one of the problems we have today is that we have, especially in the Hispanic community, as was indicated by Mr. Bustamante earlier, we have a migrant population, a population that for purposes of employment moves from one place to another. Sometimes folks in that kind of mobile existence don't understand what resources are made available to them.

Do you not believe that we should inform them as to what those resources are by some means?

Mr. BODE. Sir, we have provided program information in materials in several languages, including Spanish. I brought with me today a display of Spanish language materials that we have.

As you may know, the Department maintains bilingual requirements for certification for food stamps and the provision of public information about the Food Stamp Program, so that in areas serving Hispanic Americans, there will be bilingual services provided, and that includes a sensitivity to migrant influx where that occurs.

Chairman LELAND. I understand. But, Mr. Bode, these posters are all in Spanish or are bilingually written, if you will. But these posters sitting here in this room, even if we were Hispanics and could not read English, would not necessarily be effectively used if, in fact, the migrant population doesn't get these materials or don't see these materials. The point I'm making is, if we don't use some measure of outreach to get to these folks to let them read this information, that information being produced doesn't mean a hill of beans. It doesn't mean anything.

Mr. BODE. I think the information is provided to States and it is provided through various organizations to migrant groups, and made available in that way.

I should also mention there are special provisions that apply to migrants in the Food Stamp Program. Migrant households may have little or no income at the time they apply for food stamps, and they may be in need of immediate food assistance even though they expect to receive income later in the month from a new grower, for example. They may therefore be considered destitute and entitled to receive expedited service. There are also special provisions concerning the manner of counting migrant income and resources in order to take into consideration their special circumstances. This affords them flexibility in making deductions from their income, which, of course, influences the benefit levels.

Also, migrant households may be exempt from some requirements such as the voluntary quit provision that you're familiar with, Mr. Chairman. There are other special factors for migrants that I might submit for the record rather than going into additional detail on that point, if you would like.

Chairman LELAND. What I would like to pursue right now is—and I would appreciate the information—but what I would like to pursue is this question of outreach to some extent.

Let me ask you, then, do you know the number of eligible Hispanics for food stamps?

Mr. BODE. I believe the answer to that, Mr. Chairman, is we do not because there are a number of factors that complicate the calculation of the number of eligibles. In part, undocumented aliens is a factor that very much complicates the calculation of the number of Hispanics that are eligible. As you are aware, there is a sizable number of undocumented Hispanic aliens present in the United States who are not eligible for the Food Stamp Program.

Also, under URCA, we are phasing in new eligibility for aliens, including a sizable number of Hispanics. So one would almost need to refine the number each few months as that law's provisions are phased in.

Chairman LELAND. Let's set aside the group of Hispanics, if you will, and look at the overall eligibility of Americans for food stamps. What is that number? There is some number out there, I know.

Mr. BODE. I guess we are calculating today that approximately 60 to 65 percent of the eligible population is receiving food stamps. That is a percentage that has remained pretty much constant since the elimination of the purchase requirement that was instituted beginning in 1979. Prior to that time the percentage was below 50 percent, in the mid-forties, I believe. So, the percentage of eligibles participating in the Food Stamp Program has increased significantly in the last 10 years. It is now in the 60 to 65 percent range.

Chairman LELAND. Let me ask you further, then, if 65 percent of the eligible population is receiving food stamps, then what is happening with the other 35 percent who are not receiving them?

Mr. BODE. I think there are a large number of things happening, just as there are many reasons why people have low income, just as there are many reasons accounting for persons being in other economic situations. A sizable number of the nonparticipating eligibles in the Food Stamp Program have income above the poverty level but would still be eligible for the Food Stamp Program. That is where our highest levels of nonparticipation tend to be. There one can get into a situation where the amount of benefits that those households would be eligible for would be relatively modest, 10, 15, 20 dollar benefit level, and they may feel that it is not worth the effort.

I certainly don't want to give you the impression, Mr. Chairman, that I feel all eligible households fully understand all of the rules for the Food Stamp Program. That most certainly is not the case. What I was trying to emphasize is that I believe there is a widespread knowledge of the Food Stamp Program being available to assist those in need.

I should also note in response to your inquiry that we have a sizable level of nonparticipation among the elderly population. I believe that is due to some extent to the fact that some elderly individuals would prefer not to receive assistance in the form of food stamps.

Chairman LELAND. Mr. Bode, you bring another point to mind, and let me ask you for the record, if you will—and you can submit this at some other point, as soon as you have the information available. I don't suggest that you should have this available.

But I would like for you to quantify the number of senior citizens who might be eligible for food stamps but who are not receiving food stamps. By the same token, what I would like to have from you is the number of children who are eligible to receive food stamps and who do not receive food stamps. I would like to know what the percentage is of that 35 percent approximately, the percentage that would not receive food stamps, the eligibility of those—Well, I'd like to know the number and the percentage of those who are children who are not receiving food stamps.

The other thing is, let me ask you in your responsibility as Assistant Secretary—I don't want to engage a question from you personally, unless you care to answer on a personal level—is it violative of the administration's ideological principle to mandate States to engage outreach programs in a program like the Food Stamp Program?

Mr. BODE. Sir, we have generally been very reluctant to require States to undertake outreach activities, not only food stamp outreach but all across the board. That reflects this administration's broader view of federalism. You may be aware that in 1981, when the administration first proposed elimination of the outreach requirement, it was simply an elimination of the requirement. That is what we find most troublesome, because it was our experience—and there was considerable testimony provided to Congress prior to 1981—indicating that it caused a good deal of wasted effort, and was a poor use of the precious Federal resources. That is certainly the last thing I believe anyone wants.

Chairman LELAND. How did you reach that conclusion, that it was a poor use?

Mr. BODE. I believe the requirement for outreach activities was viewed as leading to unnecessary efforts, efforts that were yielding no effect. That is the basis for my characterization. We had these broad, sweeping requirements and they often gave rise to a poor use of resources, required activities that really had no significant effect. That's why we believe State discretion in these matters makes more sense.

Chairman LELAND. Mr. Bode, your administration came in here in 1981, and that was the first year you came in here. You didn't have enough time to determine whether or not outreach was cost-effective.

Mr. BODE. Mr. Chairman, you may be aware there were a number of us around reading records from hearings long before that. There was a knowledge of testimony that had been provided and a significant level of interest in the programs.

Chairman LELAND. Very simply, Mr. Bode, let me suggest that, as we have discussed in the past, I am really concerned about the

growing number of hungry people in this country and those who are eligible and who are not receiving food stamps, and a growing number of those people happen to be children who have little or nothing to do with their own fate or destiny. So I am really concerned about them.

I believe that if, in fact, we had some kind of outreach program, that, indeed—of course, we have a philosophical difference about this—and that's not to forgive you, by the way——[Laughter.]

But if we had these outreach programs, certainly we would be able to find these children and feed them. I think it's a white mark on America's history for us to have hungry children in our society—white versus black mark, I might add.

Mr. BODE. Mr. Chairman, I think I should note that we continue to have a Food Stamp Program that is very responsive to changes in economic conditions. Our level of participation is higher now than when we had these mandated outreach activities, though that is largely because of the elimination of the purchase requirement. We feel that our responsibility is to assure access to the programs rather than to mandate State activities for mandatory efforts to sign people up. As long as the program is there and available and reasonable access is provided, that is the requirement we feel is important, and we do feel it is generally being met.

Chairman LELAND. Under your federalism, you don't think that the government has a responsibility to care for the people who are suffering from hunger and malnutrition in this country?

Mr. BODE. Well, sir, I think I would like to note that we have got some good news on that front.

Chairman LELAND. You've changed your mind.

Mr. BODE. As you may know, poverty rates, unemployment rates, are on the decline; inflation remains low. We have seen some very good information come out about the quality of diets in the low-income population of the United States. Things are generally looking good. You know that the number of people applying for food stamps is down significantly. That, too, goes back to the responsiveness of these programs to the——

Chairman LELAND. Mr. Bode, hold on just a second. Stick a pin in that. I mean, I appreciate what you're saying, but let me suggest that there is also a school of thought that because of the morass of redtape that one would have to go through to get food stamps, to qualify—and by your own admission sometimes people find that too cumbersome to deal with. They would rather, to some extent, not get food stamps than to go through what it takes to get food stamps.

Could that decline not also be attributable, at least appreciably so, to the fact that people just don't want to go through the problem of going through the redtape to get food stamps?

Mr. BODE. I think that any time one asks that an applicant, for any form of assistance, provide information, that there is some applicant burden associated with that request. I believe the applicant burden in the Food Stamp Program is reasonable. I believe it has not changed markedly from times in the past. It has not changed markedly over the last 10 years, in my general experience. If there are specific items that you would care to address, I would be very pleased to talk with you about those items that you feel constitute

an unreasonable burden. We simply have to strike a balance in addressing the needs, between providing good access to address the needs of low-income Americans, and assuring that assistance is provided to those people who deserve and need the assistance and not to others, and that the level of assistance be appropriate under the law to the need that we are seeking to address.

Chairman LELAND. Well, we will pursue this whole issue of the fundamental problems that I have with what your Department does or does not do in these matters, and we should continue to pursue those. But the purpose of this hearing, of course, is to refine interest to what is happening in the Hispanic community.

In that light let me ask you, the research conducted by the GAO indicates that three U.S. Department of Agriculture studies are in progress, which will provide national information on Hispanic participation. Is that not correct? You do have three studies going on?

Mr. BODE. Yes, sir, at least three.

Chairman LELAND. At least three.

Mr. BODE. The Food Consumption Survey I reference is presently in the field. A continuing survey on food intakes of individuals is not in the field at this time, eventually it will be. It is scheduled and we are planning to receive farther out information on Hispanic food intakes there. And also presently I can call to mind an analysis of targeting in the WIC Program where we are seeking to identify means of better targeting WIC assistance.

Chairman LELAND. We would like very much to have as much information, as soon as you get at least near to a formal report in these different ideas, as soon as possible.

Mr. BODE. Oh, yes, sir. We would be very pleased to do that. If I may, I suspect we may have other activities that we would be pleased to report to you on as well.

Chairman LELAND. According to the recent GAO report, USDA program officials cite the lack of centrally compiled data about Hispanic participation, the absence of a demand for racial or ethnic data and the burden of local agencies for compiling ethnic data as the reasons for the lack of Hispanic participation information.

How difficult would it be to expand existing data collection systems to include specific information on Hispanics?

Mr. BODE. I guess it has been our experience, sir, that it would be fairly difficult. It is difficult to quantify in response to that question. An example would be in schools, school lunch applications. We try to gather what information we can there, but one does also get to an applicant burden issue the more questions that are asked. And believe it not, it is OMB who seeks to have us limit our applicant burden.

Chairman LELAND. Those are some bad people over there.

Mr. BODE. Sir?

Chairman LELAND. I know you agree with me. Those are some bad actors over there.

Mr. BODE. They make my life very interesting always.

So it really depends on the program. We would be pleased to talk with you about specific information needs that the committee has and efficient ways of collecting that information.

Chairman LELAND. Very good.

Doctor, what impact will the proposed cuts in the National Center for Health Statistics' budget have on your ability to collect accurate and timely data on Hispanics? We talked about a need for greater resources. What impact does this have?

Dr. FEINLEIB. The main problem we are having at the present time is with regard to the proposed Third National Health and Deficiency Examination Survey, where we had been hoping to be able to have a large enough sample size to be able to get subgroups of the Hispanic population, Mexican-Americans as well as Puerto Ricans. Under the current request we will be able to get data on the Mexican-Americans and the total Hispanic community, but not on any of the other subgroups.

Chairman LELAND. The total Hispanic community but not on the——

Dr. FEINLEIB. The Mexican-Americans as a subgroup but none of the others.

Chairman LELAND. Well, the others, by the way, make up a pretty substantial number of folks. Puerto Ricans represent 12 percent; right?

Dr. FEINLEIB. That is correct.

Chairman LELAND. But you have the others. The others would represent some 19 percent. And if you add in the Cubans, that is even a higher number—24 percent.

Dr. FEINLEIB. Of the total Hispanic community, we will be able to get specific data on the two-thirds that are Mexican-Americans.

Chairman LELAND. The two-thirds that are Mexican-American.

Dr. FEINLEIB. But not on the subgroups of the other one-third.

Chairman LELAND. But won't that hurt us in terms of what we are trying to determine here?

Dr. FEINLEIB. The information will not be available for the specific problems of those subgroups.

Chairman LELAND. In turn, it hurts us because we have to have information in order to resolve the problems that exist. And again what happens, the effect is that it becomes even more cumbersome and more near impossible for us to serve the interests of those folks.

Annual census data collections do not include information on the total Hispanic population. How does this lack of information restrict your collection of data on death rates for the population group?

Dr. FEINLEIB. Yes, the Census Bureau does provide estimates of the Hispanic population in the year of the census, but it is more difficult to get estimates for the intercensal period where it has to be based on estimates and indirect counts and samples. This means that we cannot give reliable estimates until we have the counts from two censuses to be able to interpolate between them, which means we will be able to provide counts from the 1980 census and we will have data from the upcoming 1990 census. But after 1990 it will be pretty much guesswork.

Chairman LELAND. What incentives can be provided to States to assure uniformity in the use of Hispanic identifiers for collecting and reporting information on births and deaths among Hispanics?

Dr. FEINLEIB. Yes. Again, insofar as our resources permit we are working actively with the States to provide them with material

about the importance of providing this information, the standard methods for providing the information, to provide material to send out to morticians and other people who have responsibility for entering this information; and then the States put in their own funds and resources to make sure that this effort is carried out, also.

Chairman LELAND. Very good. Now the Chair, as you have heard, has to go vote. I appreciate both of your testimonies. Thank you very much for your continued participation. We will have other questions to ask you as we go on with trying to develop some information on Hispanics for the purpose of serving the responsibilities of this committee.

The Chair will then dismiss these witnesses. I will be back as soon as I can make it over to the floor and vote and come back. I will be right back.

[Recess.]

Chairman LELAND. Dr. Feinleib, let me reconvene for the purpose of the question that you just raised with me. Reconvene right away the committee hearing for the purpose of getting your response on the record.

There was considerable discussion about how "Hispanic" is defined for the purpose of gathering this information. Can you give us your understanding as to how we define "Hispanic," for purposes of the record.

Dr FEINLEIB. Thank you for that question. It is a complicated one, but very briefly, we do work on a self-reported system. It is what the respondent to a survey or questionnaire or an informant with regard to birth certificates or death certificates report as their race and their ethnicity as two separate items.

In previous years, there have been statistical rules. For example, for children on the basis of what the reported race of the parents was as to what the children were. That is no longer being done. We decided that creates a lot of problems, and now the data will be reported in terms of the self-proclaimed or self-reported ethnicity status of the parent, usually the mother in the case of birth records.

And the caveat is that we ask the respondents to report their race or ethnicity as they represent themselves in their communities. So there is that kind of adjustment system, if you will.

The interviewers, the people who take the data, are usually instructed not to make any self-assessment with regard to what the respondent informs of us.

Chairman LELAND. In Puerto Rico, in Cuba, in other countries where Spanish is spoken, Hispanic countries, if you will, there are people who are black people. They come to this country, they speak with an accent when they learn English, they speak fluent Spanish with the different dialects, if you will. How do you report that person?

Dr. FEINLEIB. We use two separate items.

Chairman LELAND. Carmen Diaz, for instance, is as black as the ace of spades, but is of Cuban origin. What is that person?

Dr. FEINLEIB. We keep them as two separate data items: one on race and one on Hispanic ethnicity.

Chairman LELAND. Now suppose she, being black, decides that she doesn't want to be identified with black people, and she says

that she is Anglo—well, not Anglo, but she is Hispanic and she doesn't want to deal with the race issue. What do you do?

Dr. FEINLEIB. If it was filled out that way, race would be reported as unknown, and ethnicity as Hispanic.

Chairman LELAND. What if her father is white? It doesn't matter?

Dr. FEINLEIB. We don't ask about dependents. It is self-reported by the respondent.

Chairman LELAND. What a dilemma?

Dr. FEINLEIB. Well, for statistical purposes, and for most of the programs, we think it is proper that the respondent as they represent to their community should report the information.

Chairman LELAND. So, then a Creole in Louisiana, who is not Hispanic necessarily but a Billy Tauzin, for instance, who is—well, as I understand it, if you are black and you are French or you are of French origin, if you are Franco-Black, Afro-Franco origin in America, you identify yourself as being Creole. If you are like Billy Tauzin, you have got a much bigger dose of the white people than you do black people, then you declare yourself as Cajun.

In your statistic gathering, you don't necessarily make the distinction; you allow for that person to make the distinction?

Dr. FEINLEIB. That is correct. We usually have a category "Other," if this is doubtful; and it is not really unknown. This is usually a relatively small proportion of the counts in any of our surveys.

Chairman LELAND. Is this the beginning of the amalgamation of the races in this country and the beginning of the dissipation of the importance of race in this country?

Dr. FEINLEIB. I don't know if I could give you an answer——

Chairman LELAND. On an official level, though. I am talking about on an official level.

Dr. FEINLEIB. On an official level, the OMB and the various agencies have responsibility for defining certain subgroups of the population as racial and ethnic minorities, so that is already defined by at least policy. Beyond those groups it is pretty much of a social problem developing.

Chairman LELAND. Not necessarily a problem.

Dr. FEINLEIB. Well, that is why I hesitated on the word.

Chairman LELAND. There is nothing wrong with being Afro-American or African-American.

OK. Thank you so much.

Dr. FEINLEIB. You are welcome, sir.

Chairman LELAND. The committee stands in recess.

[Recess.]

Chairman LELAND. We are going to now reconvene the hearing, and we are very fortunate today to have Agapito, Juanita and Paul Cortez from San Antonio, TX.

This Mexican-American family has an important perspective to offer us on the problems they have encountered raising a family on an income below the poverty level and the difficulties they have had in accessing food assistance programs. Mr. Cortez is presently working part time as a custodian, Mrs. Cortez is a food service employee at one of the schools in their community, and Paul is currently enrolled in high school.

The Cortez family is accompanied by Rose Valdez, a social worker at El Carmen Health Clinic. The clinic, run by the Daughters of Charity of San Antonio, has been serving Hispanics in the community for the past 25 years. Ms. Valdez has been working with the Cortez family over the past few years in helping them to access public assistance programs.

The third witness is Mrs. Nylda Gemple, who is the Director of the San Francisco WIC Program. She is an active member of the Hispanic community in the Bay Area and has devoted much of her time and energy to alleviating hunger amongst Hispanics.

I would also like to note that when the select committee conducted a field hearing in San Francisco in 1984, Mrs. Gemple was kind enough to arrange for us to visit a WIC nutrition education session, which was not only a delight for us to visit but it was also a very informative session that we had there.

Because of the time that we are faced with, or the problem of constraints that we are forced to face now, we are going to also combine the last panel, and our final two witnesses will be Dr. Fernando Mendoza, who is an Assistant Professor of Pediatrics at the Stanford University School of Medicine, who I understand has to catch an airplane. Is that correct?

Dr. MENDOZA. Yes, sir.

Chairman LELAND. I apologize for the lateness of the hour.

He has conducted extensive research on the health of Hispanic children. Dr. Mendoza has been of great assistance to the subcommittee in helping us track the nutritional and health status of Hispanics.

And finally, Mr. Adolf Falcon, who is the Policy and Research Director of the National Coalition of Hispanic Health and Human Service Organizations. This group has been a successful advocate for Hispanic health issues on a local, State and Federal level.

Dr. Mendoza, let me ask you, what time is your flight scheduled to leave?

Dr. MENDOZA. At 4:45.

Chairman LELAND. Let me ask the other members of the panel, if you will, to allow for Dr. Mendoza to please present his testimony so that then he can take leave and catch his airplane.

Dr. Mendoza.

STATEMENT OF FERNANDO S. MENDOZA, M.D., ASSISTANT PROFESSOR OF PEDIATRICS, STANFORD UNIVERSITY SCHOOL OF MEDICINE

Dr. MENDOZA. Thank you. Chairman Leland, I would like to thank you for the opportunity to testify today. My colleagues and I from Stanford University and the University of California have been examining the health and nutrition of Mexican-American children, as well as other Hispanic children. This has been funded through the Bureau of Maternal and Child Health.

I was asked by your staff to respond to the question: Do we have enough data on Hispanics to do appropriate health care research? I would like to answer that question in three parts. First, by examining the information we have had in the past; second by evaluating the information we currently have with respect to Hispanic; and

third, giving you my opinion about the type of data that is still needed to do comprehensive health care research on U.S. Hispanic children.

First, in terms of the historical aspects of data on Hispanics, and particularly Mexican-Americans, I think we can break down the information into two basic categories: those studies that were done by private researchers and basically without aid from the Government, versus those studies that were done by the Government. The studies done by independent researchers generally provided us with a picture about Mexican-Americans and other Hispanics that showed that there was a great deal of poverty. The effects of this poverty on Hispanic children were seen in the areas of growth, nutrient intake, and health status. However, the problems with these studies were that they were of very small samples, so that at times they included only 50 to 100 children. The other major problem with these studies was the fact that they were usually done in local facilities, facilities that were mostly for the poor. At times what we were really seeing from the independent studies were a picture what was happening in local poor neighborhoods along the border or in institutions like public health clinics that were serving the poor. They did not provide us with the broader picture of what the whole Hispanic or Mexican-American population looked like.

The other methological problem with these studies was that of standardized methods. With multiple independent studies, every investigator does not always gather the same information in the same way so that the information obtained may differ in the types of measurements. This makes it very difficult to compare different studies. However, the one thing that seems to be consistent in these studies was the fact that poverty had a major impact.

If we look at the Government studies, it is interesting to note that governmental studies have looked at the health and nutrition of children about since the 1960's. The first study, the health examination survey, was a very complete study in that it looked not only at growth and health but also school performance of children, and it was one of the better studies done by the Government. However, Hispanics were not identified. Hispanics were lumped with whites, and therefore they did not exist in that study.

A 10-State survey was done 1968 to look at the problems of malnutrition. For the first time this study, as a Government study, looked at Hispanics. It looked at Hispanics, Mexican-Americans in Texas and California and Puerto Ricans in New York City. However, one of the major problems with this is that there was no self-identifiers. One was listed as Hispanic if his name appeared on a Hispanic surname list. If your name did not appear on that list, you were automatically listed as white.

Now the interesting thing about this list, is that it has grown almost twice in size since the late 1960's. So there was a significant bias in that list against Mexican-Americans and other Hispanics. Therefore, when the data was collected the sample size was so small that nobody could make any reliable estimates. So we were there but we were not there in the 10-State survey.

The other thing that was of concern was that there was no socioeconomic diversity in the sample. The 10-State survey divided States into high income and low income, but within those States

there was no assessment of poverty. Why this was of importance was the fact that in order to look at the issues of how one culture differs from another, particularly among Hispanics, one has to take into account poverty, and poverty can only be examined if we have a broad-based sample of individuals. As you know, Mexican-Americans have about 25 percent of families under the poverty line, and Puerto Ricans have 40 percent. So this was an important factor that was not measured.

The other thing I think was missed, and to the detriment of the Hispanics, is the fact that there is variation within Hispanic populations. There are variations within Mexicans, for example, that would be missed on the basis of just listing people as Mexican or non-Hispanic. This is the process of acculturation. In Texas, as you may well know, there are families that are Mexican-American that have been there for generations, before this country was a country. So those families could be viewed the same as somebody that recently immigrated in from Mexico, and yet I would venture to say that those are two different groups of people.

Now few investigators have taken that into account. And one of the problems of this lack of information about acculturation is that you make everything one group and you lose the sensitivity and ability to understand how these factors affect health care delivery, health behaviors and nutritional behavior.

The national health and nutrition examination surveys of the 1970's, good surveys but they again did not look at Hispanics. They were not oversampled, so the data there were very small and, therefore, could not be used. However, the HANES II, there was some listing of self-descriptors for Hispanics and that would help; but, again, the sample size was so small we couldn't really do very much with that survey. Moreover, when one does national surveys it is important to have surveys that are valid for those populations and for the Hispanic or Spanish-speaking populations none of the governmental questionnaires were translated into Spanish, and therefore what that resulted is information being obtained from people in a different language that had to be translated somehow, and usually it was translated at the level of the interviewer or sometimes by a family member that just happened to be around. Without that standardized translation of questionnaires, we could not be sure that the reliability of the data was there.

The major study by the Government to use self-identifiers and to try to make some attempt to look at the health of Hispanics was the national health interview survey. This survey, as you may know, is an assessment, by home interview, of health care status. This survey actually has provided the only, or one of the major publications dealing with Hispanics in this country. The Federal Government prior to that had not published anything that listed Hispanics or concentrated on Hispanics. This publication was entitled The Health of Hispanic, Black and White Americans and was done by Trevino and Moss from the National Center for Health Statistics.

The important aspects of this study was: one, it showed that Hispanics had indicators for health and health care services that were quite different for whites and blacks and also that, more importantly, within Hispanic subgroups, Mexicans differed from Puerto

Ricans and they differed from Cubans. This is a very important factor. I would like the committee to understand that Hispanics are not all one group but are quite different, and they have significant differences in their health care indicators and health care status. The problems, again, with the health interview survey was the fact that they were not translated into Spanish, so the reliability of that data was in doubt.

Moreover, Mexicans particularly, and Puerto Ricans also, have a lower usage of health care services, so that since this information is based on whether a physician has told that person whether they have a health problem there would be a significant bias in the information because people would not know that they had a health problem.

That brings us up to about 1980. One of the things that you should also note is that there really was no mortality data on Hispanics. We did not know and we still do not know I think reliably what Hispanics are dying of. We don't know what children die of that are Hispanic. We don't know what elderly Hispanic individuals die of. We have some views of it, and one of the interesting findings that was mentioned earlier was infant mortality.

California has had data that Williams, et al., have looked at, and one of the interesting findings there is the fact that women that are born in Mexico have better infant mortality and low birth weight infants than Mexican women born in this country. What that tells us is that there is some factor that may have cultural implications. This factor may not only affect the pregnancy but may be buffering the effects of poverty. This is a very important finding that we need to pursue to determine its validity and meaning. However, the information is not currently available to do that.

One of the major studies on Hispanics to come into existence is the Hispanic HANES. The first national study on Hispanics, and this was on Mexican-Americans, Puerto Ricans, and Cuban-Americans. The Hispanic HANES tended to overcome many of the problems of the previous studies, and I think has done an excellent job. We have been analyzing that data over the last 2 years, and I would like to relate very briefly just two major findings that has to do with poverty and culture.

Poverty has a continued major effect on the growth of children, particularly in their stunting. When we look at children under 12 years of age, poverty is the major factor that determines their height. If kids are equalized in terms of socioeconomic class with other white children, they grow as well. But if they are poor, they grow less well. For adolescents this seems to be a problem, but not as much. There seems to be other factors there.

One of the other interesting findings is that obesity is becoming a major concern among Mexican-American children. People may say obesity is not a sign of hunger, but I think it is a sign of malnutrition or overnutrition. And that is an area that needs to be looked at because obesity is linked with subsequent cardiovascular disease and diabetes.

The other interesting findings I think were the fact that chronic conditions or chronic medical disease was really about the same level as that of the U.S. norm, and not much affected by poverty. But when one asks the questions to the individual subjects, in this

case mothers of children and the children themselves, how do they feel about their health, there is a dramatic difference between the health status perceived by the physician and that perceived by the Mexican-American family. Physicians perceived 1 percent of the Mexican-American children in poor health, mothers perceived 15 percent, and children, from 15 to 20 percent.

One of the very important findings was that poverty and culture or acculturation have major impacts on this health perception. Mothers that were Spanish speaking considered 25 percent of their kids to be in poor health. Mothers that were English speaking only 7 percent. The adolescent that was Spanish speaking, 35 percent of that group considered themselves to be in poor health. The adolescent that was English speaking, 15 percent considered themselves to be in poor health. This would suggest that there is something there that has to do with culture that we need to examine.

The problems with the H-HANES are, I think, not many. However, I would list the sample for Cuban-Americans as one. Second, and perhaps more importantly, is that the H-HANES was able to identify only those Hispanics that had a permanent residency, so that those people that were migrant, or in the case of adolescents that were out of the house were not identified. Those are high risk groups that we need to have information about. Third, there was no comparison groups, therefore we couldn't really compare with black or whites. Fourth, we had limited information on acute illness, and acute illness I think in poverty has a major impact. I know from my clinical experience with children that recurrent illnesses are important factors in poverty, and I think the next surveys that are done should assess this aspect.

But perhaps more importantly for me, being a pediatrician, is the fact that none of the H-HANES data has any information, or really significant information on the function of the child. We do not know how well Hispanic children are functioning. We may know what the height of the child is or what the hemoglobin value is, but we don't know how the child is performing in school, how fit is the child, and overall what is happening with the child. Therefore, I would make the following recommendations to your committee.

First, it is vital that we obtain accurate mortality data for Hispanics. Currently we don't have any information on this, and without that we won't know what Hispanics are dying of.

Second, national surveys need to include Hispanics and be able to identify major Hispanic subgroups. Again, Hispanics are not all the same. We need to acknowledge that. This means having adequate sample size for Hispanic subgroups in order to obtain reliable estimates. Where this plays a major role, as you know, is in HANES III where decreasing the sample size will basically eliminate all information on Puerto Ricans that will be useful. We need to have black and white subject samples in the same survey. We need to look at the level of acculturation, make sure the measures of the survey are valid.

And again, for children, we need to look at function. Function is important. We need to know how well those children are going to be able to function and what is the likelihood that they will be able

to do better. Particularly for poor children, what the likelihood will be that they will be able to leave poverty.

The third recommendation would be that we do not only national surveys but surveys on those that are mobile; that is, those who don't have permanent residences and would be lost by the Census' way of assessing people. We should try to look at the homeless migrants, and those perhaps should be done on a State level.

Fourth, I think that it is important that we go beyond cross-sectional studies such as H-HANES and move on to longitudinal studies as well. One of the factors for children is that they are growing and they are changing over time. We can look at them at one time but we don't know anything else about what is happening over time unless we do longitudinal studies. If we are interjecting nutritional programs and health programs to make children better, we need to know if these programs are having an effect. We currently don't know that. We can only say that there is an association. So the longitudinal aspects of studies need to be looked at.

Fifth, funding needs to be available for the national surveys so that we are not cutting back on samples.

And last, I think there needs to be funding by NIH, Maternal and Child Health and other groups to independent investigators in the university communities because I think in that way we can share the responsibility of looking at this data.

Thank you.

Chairman LELAND. Thank you very much, Doctor. Let me suggest that I did have some questions, but what we will do is submit them in writing and ask you to respond. Then we will enter your responses into the record.

Dr. MENDOZA. Thank you.

[The prepared statement of Dr. Mendoza appears at the conclusion of the hearing, see. p. 125.]

Chairman LELAND. I know you have a plane to catch, so why don't we excuse you now.

And I understand also that we have another panelist who has a plane to catch at 5 o'clock. We are going to impose on our panelists. Why don't you proceed?

STATEMENT OF NYLDA GEMPLE, DIRECTOR, SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC), SAN FRANCISCO, CA

Mrs. GEMPLE. Thank you, Mr. Chairman. I am Nylda Gemple. I am so pleased to have come again before you and this committee to share my concerns about hunger in America.

I work for the San Francisco Department of Public Health, and my concerns are twofold: one as a health professional, and the other one as a concerned American citizen of Hispanic descent—at least until we started discussing Hispanic descent 2 or 3 hours ago. For the last 20 years I have been employed as a professional in the area of public health, and for the last 8 years as the Director of the WIC Program in the San Francisco Department of Public Health.

Before I describe my concerns about Hispanic women and their access to health care and public assistance programs, I would like briefly to discuss the data that we have collected in California.

There is a table that has been provided for you, and in that table it will reflect that—I am going to make this brief in the interest of time. In that table it does reflect that of the 280,259 participants that we have in California, 157,362 were of Hispanic descent. That amounts to 56.1 percent of the population.

As we further break down the total into categories of women, infants and children, the Hispanic participation becomes more emphasized. The total for women was 94,117, with Hispanics amounting to 56,011 or 54.5 percent of the population; infants totaled 108,557, with Hispanics accounting for 65,128, or 59.9 percent, and children totaling 77,585, with Hispanics amounting to 36,223, or 46.7 percent.

In San Francisco for October 1987, our program served only 8,228 participants. Of those 3,594 were Hispanics, amounting to 43.6 percent of the participation. The table again reflects the Hispanic participation by categories. I would like to bring to the attention of this distinguished committee that Hispanics are not a majority of anything in the city and county of San Francisco. Other cultural/ethnic groups, especially Southeast Asians and blacks, aggressively see enrollment in the WIC Program and compete for the same services.

Today I will be addressing the importance of proper nutrition in pregnancy, the shortcomings of programs such as AFDC and why the WIC Program is needed to insure both nutritional adequacy and, hopefully, prenatal care for California's low-income mothers.

Studies have repeatedly shown that inadequate diets during pregnancy result in increased pregnancy complications and an increase in low birth weight infants. Conversely, proper diet can and does play a role in alleviating pregnancy complications, including low birth weight babies.

The nutrition needs of pregnant and lactating women and infants are greater than any other group due to rapid physiological growth. Dietary requirements are increased for all nutrients above the normal recommended dietary requirements. It has been well documented that a women's nutritional health before she becomes pregnant has a significant impact on her pregnancy outcome. Many of the factors which affect birth weight are nutrition related. These include her weight before she becomes pregnant, which tells us if she was getting adequate calories, how many times she's been pregnant, which may determine her nutrient stores, as well as whether she has complicating medical conditions such as diabetes, high blood pressure or simply depleted nutrient reserves due to a lifelong lack of adequate food.

Low birth weight babies account for over 70 percent of the infant mortality casualties. Those who survive often do so under very impaired circumstances, robbed before birth of equality of opportunity.

Think about how few low-income women consume a high quality diet before pregnancy and you can begin to imagine the kinds of problems that we face across the Nation.

The Supplemental Food Program for Pregnant and Lactating Women, Infants and Children is a USDA program which gives nutrition education and vouchers to buy certain foods. Often that program has a 3- to 8-week delay before giving benefits. These foods

contain the nutrients most often lacking in the diets of these women and children: calories, iron, vitamin C, vitamin A, and protein.

Several evaluations of the WIC Program have shown that women who receive WIC while pregnant have higher birth weight infants. Because WIC requires a physical examination to determine if a client is anemic, underweight, overweight, or otherwise at risk, clients who might not otherwise receive health care are placed in a position where problems can be identified and proper intervention applied. This leads to higher than usual enrollment in prenatal care, thereby eliminating one of the greatest risk factors in the sequence leading to high infant mortality. The longer the participation in the WIC Program, the better the outcome. Unfortunately, under the current WIC funding, only 33 percent of the eligible women, infants and children are enrolled due to caseload limits.

WIC benefits are also associated with greater likelihood of children having a regular medical provider and being properly vaccinated. They are also associated with some evidence of better cognitive performance in children. But the bitter irony is that current enrollment priorities focus on prenatal clients, keeping children who would otherwise be eligible from being enrolled.

The long-term consequences of denying proper food to various generations of Americans is yet to be seen. The short-term consequences are what we deal with daily; that is, anemia, shortened attention spans, fatigue, and lack of interest in learning. It is impossible to learn on an empty stomach. Under these circumstances, equal opportunity is a cruel joke, rather than a reality for all too many.

In San Francisco, we have only scratched the surface of addressing the real needs of a community inhabited by recent immigrants from war-torn Central America or the refugee camps of Southeast Asia. Families with years of inadequate diets imposed by the stressful reality of survival encounter new problems in this country. Language is the most obvious, but by no means the only barrier to getting ahead. Among other factors interfering with the accessing of health and public assistance are those encountered by Hispanic families in the areas of severe psycho-socioeconomic conditions. It can be said that Hispanic families rank as the poorest among the poor since many of them are not residents of the United States, and consequently are barred from receiving public assistance benefits. By nature they are not aggressive seekers, and that compounds their loneliness and isolation.

Many of our Hispanic moms are single parents and without friends. Their extended family concept—so revered by our culture—has been cut off. Since a social support network is non-existent among them, they have become among the most vulnerable ethnic groups of our society.

As efficient and cost-effective as the WIC Program has proven to be—because of every dollar spent on WIC, $3 is saved on health care—WIC is not the answer to all our health and hunger problems for the program only services, as I mentioned before, one-third of its eligibles, focusing on prioritizing pregnant women enrollments first. The prioritizing methods have the effect of precluding children access to the program as opposed to women and infants. A

mother does not go home and eat by herself; what we hear and know is that she will share her WIC foods with the rest of the family, which brings me to another issue that I hope in the future this committee could address, and it is that of having more support in Congress for breakfast and school lunch programs.

I thank the committee for giving me the opportunity to come and testify again. Thank you very much.

Chairman LELAND. Thank you, Mrs. Gemple. Let me thank you for your continued support of the committee by way of your participation each time that we have asked. I have fond memories of the time when Sala Burton had initiated a Select Committee on Hunger hearing in San Francisco and you were so kind as to show us around and to give us the wisdom of your advice. We certainly appreciate that.

Mrs. GEMPLE. Come back anytime.

Chairman LELAND. We will do that. Aside from that, San Francisco is such a lovely place to visit.

Let me thank you again. I know that you have a plane to catch. If we have questions, we will submit them in writing and keep the record open for the purpose of receive of those responses that you might give.

Mrs. GEMPLE. Adios.

[The prepared statement of Mrs. Gemple appears at the conclusion of the hearing, see p. 146.]

Chairman LELAND. Adios. Hasta luego. Muchisimo gracias.

Bienvenida a familia Cortez.

Mr. AGAPITO CORTEZ. Como esta.

Chairman LELAND. Muy bien. Muy bien. We are so glad to have you here today. I am going to read the record to find out if our recorder speaks Spanish or at least knows how to record Spanish.

We do want to welcome you. Thank you so much. We apologize for the lateness of the hour. We didn't save you for the last because we felt that you were the least of the panelists. We saved the best of you, as a matter of fact. Let me say that it is the ordinary citizens who suffer from the many problems of our country who are willing to come forward and testify before these congressional hearings that give us the impetus to go forward with some times legislation, some times the mandate of policy that protects so many other Americans, and we know that it takes a lot for folks like yourselves to come and tell your story to the Congress of the United States.

While there are only two of us who are here present, let me assure you that the many other members of the select committee will read your testimony and have their staff to analyze the testimony for the purpose of trying to do what it is that we can to resolve the many problems that confront us, especially on the issue that we are concerned about here today.

I also acknowledge the presence of Mr. Falcon, and we appreciate your being here.

Let me ask now that the Cortez family testify. I don't know in what order you want to make your statements, but please proceed as you wish.

STATEMENT OF AGAPITO CORTEZ, ACCOMPANIED BY JUANITA AND PAUL CORTEZ

Mr. AGAPITO CORTEZ. My name is Agapito Cortez. I am 48 years old and I am an epileptic. I hear about these food programs that are available, and sometimes I hear that they are going to be cut. A man in my position with a family, let's say that I cannot find a job and I depend on these food stamps to keep me going, to keep my family going, and if they are cut, then what am I going to do.

I tell my children: You finish school. Don't drop out of school, so you are not in this position that I am.

When you are an epileptic, you are different in a different world. You have to compete with everybody, everything. You go and apply for a job and they look at your application, you have all the qualifications except you are an epileptic; you are required to do certain things. The man is there looking at you, you know. He says, "Umm. Well, Mr. Cortez, this is good," you know, "give him a cup of coffee." When he gets down to the medical part and the restrictions, he goes like that [indicating] and the expression is gone. You know, yourself, you are out of a job. He will not tell you he won't hire you, but he will not call you. So I have to go back and get odd jobs here and there to provide for the family.

For 15 years that is what I have been doing. I managed to get two of my oldest boys through high school and to graduate. I am working with him [indicating Paul]. After him, I got two girls left that I have to still provide for. But if no one is going to hire me, how can I survive? Food stamps they give you to buy groceries, but you need paper, pencil, pens, tennis shoes, clothes for the kids.

If they are all in a program, they come home and say, "Dad, there is a project at school. I need $10."

And you look at him, "Oh, that's right, I know. We don't have it."

Then he comes after a while, he says, "Well, why should I continue school? I prefer to go to work."

But I try, like with the other ones: "Look, you go and let me work."

He says, "Well, Dad, you are sick and you are getting old."

"But still you let me work. You just go to school."

So far next year, I hope, he is 18 years old, I hope he graduates. I tell him, "I don't care if you are 20, you need to graduate. I don't want you to be another Mexican percent that you drop out of school."

Because I don't know what you people mean by, you know, Hispanic because I am a Mexican. When I was called before the Draft Board I was called as a Mexican. Not as Hispanic or whatever, you know, but as a Mexican.

So I tell them that, you know, these programs, they will help a lot but yet the programs don't get to the people. We live in the little town of Le Soya, right on the outskirts of San Antonio. The posters that they had a while ago up there, I had never seen them. There are people out there that don't have transportation. We lived 2½—just 2 years without electricity because I could not afford it.

Chairman LELAND. How long, sir?

Mr. AGAPITO CORTEZ. Two years because I could not afford electricity. We used a lantern every night, and that is how they did their homework.

But I try, you know, try to make a living as best as I can. I am a janitor. Been a janitor for more than 25 years, but due to my epilepsy nobody wants to hire me.

The Social Security office says: Yes, you can work. Get a job.

But who is going to hire you?

The doctor says: "Yes, you are able to work. Go out and find it."

But who is going to hire you knowing that you are not going to be able to work fast enough, there will be days that you are going to have to stay home because of your epilepsy, you cannot operate electrical equipment, you cannot climb a ladder. So most places, you know, they look at you and say, well. They just won't call you. They won't say no because they are afraid to say no, but they won't hire you.

And up to this date, I have not been helped with any kind of programs. It has just been between me and my wife, and some times the kids will get a summer job so they can help out. And you know I am not getting any younger, so I am going to need some help pretty soon.

Food stamps is a good program. The cheese that they give is very good.

Chairman LELAND. The cheese, you said?

Mr. AGAPITO CORTEZ. Yes. The cheese program is very good. At least when your food stamps run out you have something to look forward to.

And the food stamps office, in my opinion, they need, you know—of course I don't see it the way they work, but they need help. Sometimes I think that those people are overworked because you go in there and they are crowded, they are tired. If you go early in the morning, well, they treat you pretty decent. After lunch, 12 o'clock, they just look at you. All they want to do is get you out of the way because they are tired. And I don't blame them. I guess if I was sitting behind that desk I would get tired too. I have heard from other friends and I have seen it myself, they might sit there 2½ hours waiting for someone to call them. And you have got your children there crying and running up and down, screaming and all that, naturally the people that are working there, they kind of get irritated. I think they do a good job, but I think they need a little bit more help, too, so they can be feeling good when we go there to have some help. Otherwise, when they are tired they are not going to function right. Just like you, if you get tired back there, you are not going to be paying attention to what we are trying to say.

People need to go out and look at the way some of us are living out there. Not what they read on a piece of paper or by percentage, they need to go out there and look. Walk and look and see the way we live. A lot of people are afraid or they are embarrassed to come and talk about it. But if people would just get out there, take their Sunday suits off or shirts off and go out there and just spend a couple of days out in the community, they can see what is happening.

All you hear, you know, what we hear from the caseworkers: "Golly, again! My taxes again! Golly! What am I going to do?" But you never hear the man is going to get an increase in his salary. You never hear about raising salaries. The only people that get their salaries are ones that are way up in the high positions on their own. But the working man does not get an increase very often. All you hear is about taxes and taxes. How can we keep up with the taxes if we don't get more money? Because if I don't get a raise—let's say, if I was an employee and I have been with this company for 6 years and I get a raise, let's say, 5 percent every 2 years. It is already eaten up in taxes. When you go buy your groceries, you pay tax.

Nowadays, you pay taxes for everything. So how can the working man compete if their salaries are not raised to keep up with the taxes and to keep up with the groceries, keep up with the kids, so you can have time to understand them?

When they come home and say, "Dad, can I have $20 to go to the movies?" You say, "Wow! Son, I can't and I am sorry." When I was growing up, of course, 25 cents, you could go to the movies, buy popcorn and a bar of candy. Now it takes $20 to send the kids to the movies. Like in my position, I only make $165 every 2 weeks. How can I, you know, keep up with these programs? And then you go ask for help and you don't get it.

Chairman LELAND. Very good. Mr. Cortez, are you speaking for your whole family? Senora?

Mrs. JUANITA CORTEZ. I am Juanita Cortez. I am 48 years old. I have six children, three girls and three boys. I am very proud that I had this chance to come here in front of this committee and talk about how I feel about all this hunger in America.

We live out in the country, La Soya. Our community is pretty large, and there are a lot of families there that are very much in low income. And they are in food programs but they do need a lot more help than just that. I wish that there were more programs available for all these people to survive.

Let's say that they get some food stamps for the month, but it will not go for the whole month. Let's say that their food stamps will go only to about the second week of the month. Now what are they going to do for the next 2 weeks of the month? They will just, you know, struggle day by day to see how they are going to get it.

In the programs for the school, there are a lot of students that don't want to go to school because they are embarrassed of the way they are dressed to go to school, you know, in front of other students who can look better than they do. They just don't want to go no more. I wish that there would be, you know, some kind of a financial—I think that when I say financial I mean moneywise, you know, to help these people to buy other things than just food. Like to go to the doctors and buy their medicine, buy other things. I feel that there could be other means of financial aid.

We have a lot of people out there that doesn't have any bathrooms inside their houses; they have to still go outside in the outhouse. A lot of them doesn't have electricity. Old people that cannot afford to get on that. That is why I am saying maybe there could be another financial help.

Chairman LELAND. Would your son like to make a statement?

Mr. PAUL CORTEZ. I am Paul Cortez. I go to Southside High School in San Antonio. I am a junior.

I kind of thought of dropping out of school to help my parents out because I knew we had problems, but I realized that if I did drop out of school I wouldn't be able to get a job because I wouldn't have an education. I try to help out as much as I can during the summer. I worked and with the money I got from there I gave it all to my dad to help build the house, to help pay the payments, and for the food.

But I guess I kind of feel down too because nobody would hire him because he was epileptic. I think there should be a job at least for people who have epilepsy to be hired and they could have money to support their families.

Chairman LELAND. Ms. Valdez, would you like to make a statement?

STATEMENT OF ROSE VALDEZ, SOCIAL WORKER, EL CARMEN CLINIC, SAN ANTONIO, TX

Ms. VALDEZ. Hi. I am Rose Valdez. I am going to give you a little bit of background about El Carmen and Le Soya. It actually is not an incorporated area. It is part of the city of San Antonio's territorial areas.

More specifically, El Carmen Clinic is a member of the national health system of the Daughters of Charity. We are also incorporated in Texas through the Daughters of Charity Services of San Antonio, and this is something brand-new. There are three other places like us. The Daughters also are in charge of the health care for the homeless, so their emphasis is on health care.

The people who use our services come from four census tract areas: 5019 is 92 percent Hispanic and 40.9 percent of those people living in that census tract live under the poverty level, and that same is true for the other four. There is not a big difference there. The educational level is about 63 percent of the people in our area over 25 do not have a high school education.

We have approximately 22 percent of our homes in that area that do not have indoor plumbing. They use outhouses, and you can derive from that the health problems that are possible in a situation like that.

I think most importantly is that this area is very much a forgotten area, and it is not unique, fortunately, in the State of Texas. And I think that families like the Cortez live day to day in survival.

I bear to differ with the gentlemen who were speaking up here earlier. I have been working in El Carmen Clinic for 2 years, and I started with one particular family, trying to get food stamps for this family and they got them in January, and I think that really says a lot about redtape. It says a lot about the fact that the Department of Human Services is willing to go the extra mile. I don't see that outreach is being done.

And there are emergency food stamps for people. When Mr. Cortez lost his job about 6 months ago he came to me and said, "I don't know what I'm going to do."

And I said to him, "Well, what are your options?"

He said, "Well, I'm going to get workmen's compensation for a while."

I said, "Well, then don't go apply for food stamps because it's a waste of your time."

And, as far as the family is concerned at this point, their financial situation is that they probably could qualify for food stamps financially. However, Mr. and Mrs. Cortez over the last 15 to 20 years have been purchasing a piece of land. It is 12 acres out in the country. That is where their homemade—their own built house is; they built it themselves. And because of that reason they do not qualify for food stamps, and I think that these are the people who fall through the cracks. And, unfortunately, these are the people that I work with on a day-in and day-out basis, so I really feel like we need to begin to address those people, the working people.

In the past couple of years—I am still a student, so I have done a lot of reading. In the past couple of years, I have read a lot about the cycle of poverty and the very most frightening thing to me is that neighborhood or the area of El Carmen where for the most part people work even if it is picking cucumbers a dollar a bag or working in a restaurant a dollar an hour, I see these people more and more relying on State aid, and I think they need to know that that is there to support them.

However, what scares me is that this cycle is beginning out there, and it scares me that many of the families that I see are afraid to challenge what could be theirs. Be it work programs, be it WIC, be it Social Security—they are not willing to fight for that even though they have it coming to them, and they are a silent people.

And when you talk about Mexican-Americans and Hispanics, I think for the most part in my own past, in my own family history I think many of them will do without before being pushed around and bruised by the system. So I think that is why many times the numbers aren't there. That is why there is 11 percent Hispanics using the food stamps system, when there are countless numbers just in our area who could qualify.

I guess I feel right now the programs as they exist under the current administration are hurting the working man and woman, they are not helping them. They are not supporting them, but rather punishing them because they are working, and that is even more frightening.

Chairman LELAND. Thank you.

Mr. Falcon.

STATEMENT OF ADOLF FALCON, POLICY DIRECTOR, NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS (COSSMHO)

Mr. FALCON. Congressman Leland, Congressman Penny, first of all, I would like to thank this committee for the leadership it has offered on bringing this problem too light, and especially for concentrating on the problem of the lack of Hispanic data. You have my written testimony. I am just going to briefly touch on a few points that I think should be highlighted.

Chairman LELAND. Thank you.

Mr. FALCON. The first of those is, Why collect Hispanic data? We have heard the problems the Cortez family has had with receiving the type of services they need. However, without data collecting and our national health data collection systems, those problems remain invisible. They are very real, they are very serious problems. But as far as the service providers, they don't exist if they don't exist in our data base.

Part of the reason they don't exist may be that for quite some time it has been assumed that Hispanics were covered under the category of "general population" or the experience of the black community, which is used as a proxy for the experience of the Hispanic community in a minority model. As we learn more we know it is inappropriate.

The second point I would like to touch on is just a quick overview of the major national health data collection systems. First of all, Hispanics are not oversampled for in any of the health data collection systems, except for the National Medical Expenditure Survey which just started this year. Without that oversampling, we have no real data on the health status of the Hispanic community. All we have are special and regional studies.

That is especially serious under two systems, the first of which is the National Health Interview Survey. For over 25 years this survey served as the cornerstone for those involved with health planning, and it has provided continuous information on the health status of America. We have no information for Hispanics under that survey save for a special study done with data aggregated between 1978 and 1980. That data has already been proven to be out of date with initial findings we are finding from the Health and Nutrition Examination Survey done for the Hispanic community.

Under that second system, the Health and Nutrition Examination Survey, Hispanics also are not oversampled for. Those two systems, the National Health Interview Survey and National Health and Nutrition Examination Survey (HANES) are the major health data collection systems for this Nation. Since we don't exist in those health data systems, once again our problems remain invisible.

And the third major area of concern is the collection of vital statistics records, death and birth information.

If I could just move right now to what I see as some of the needs for Hispanic health data collection and how some of the problems we have been talking about today could be solved. Very simply, the first thing that has to be done is to oversample for Hispanics under our national Health data collection systems. With that type of information we could get the first real data on the status of Hispanic health. An example of just how far we are from that point, however, comes under the HIS survey that is going to be fielded next year. Under that survey there is going to be a special supplement focusing on diabetes. As I am sure you are aware, for the Hispanic community diabetes is some three to five times more prevalent than it is in non-Hispanic white communities. We will not be oversampled for in that diabetes supplement.

The second area that needs to be dealt with is the area of vital statistics. For the first time Hispanic identifiers are being included on the model birth and death certificates that were released late

last year. The problem with that identifier is that proper technical assistance is not being provided NCHS to the people that have to use that identifier. If that identifier is not used properly, we are not going to get real mortality or fatality information.

In the area of nutrition, we have some information that is sitting there. There has been no money made for analysis for it, and that is under the Hispanic Health and Nutrition Examination Survey. The dietary tapes have been released for that survey. Very little money has been given toward analysis for that survey, and that is my fourth point.

Under analysis, a lot of data is collected in this country. Very little of it is analyzed, unfortunately. In the two major health reports, Health United States and the Report to the President and Congress on the Status of Health Personnel in the United States, Hispanics are not mentioned and, as Congressman Richardson mentioned before, only briefly in the Health Professional Report, and in Health United States there is not one single mention of Hispanics.

If I could just also speak to some of the answers you received from NCHS which were inappropriate. You were given figures for birth rates for the Hispanic community. Those are not national birth rates. Those are birth rates for a selected number of States and aren't a nationally representative sample. You were given a level of chronic and acute conditions for the Hispanic community. That data does not exist per se; it comes from the 1980 HIS data, which we found is not appropriate to what is going on today. For instance, the Robert Wood Johnson Foundation has conducted a survey of access to health care. They conducted it in 1982 and 1986. In that 4-year span they found a 50-percent rise in the level of uninsurance among Hispanics. You were given death rates for Hispanics. I think the most powerful thing I could say about the status of health data collection in this country is that I cannot sit here today and tell you how many Hispanic men, women, and children die in this country every year.

If you have any questions, I would be happy to answer them.

Chairman LELAND. Thank you very, very much. I want to thank all of you.

[The prepared statement of Mr. Falcon appears at the conclusion of the hearing, see p. 154.]

Chairman LELAND. Let me ask my colleague, Mr. Penny, if he would have any questions.

Mr. PENNY. I have a few for the Cortez family. Mr. Cortez, you indicated you get jobs as you can, and then later on in your testimony you mentioned an income of $165 every other week?

Mr. AGAPITO CORTEZ. Yes. That is part time that I work, 3 days out of the week.

Mr. PENNY. Three days a week for which firm?

Mr. AGAPITO CORTEZ. I work at El Carmen Clinic. They give me the job to clean up—mop and sweep in the evenings.

Mr. PENNY. It is maintenance work or janitor's work?

Mr. AGAPITO CORTEZ. Janitor's work.

Mr. PENNY. And where do you hold that job at?

Mr. AGAPITO CORTEZ. At El Carmen Clinic.

Mr. PENNY. At the clinic. Oh! At the clinic where she is employed.

I don't want the clinic to be embarrassed by this. But what is the hourly wage there? Do the numbers for me quick.

Mr. AGAPITO CORTEZ. About $5 an hour.

Mr. PENNY. About $5 an hour? And that is the only job—how long have you been working at the clinic on a part-time basis?

Mr. AGAPITO CORTEZ. I was working there, first it was just, you know, helping them out and then——

Mr. PENNY. Yes.

Mr. AGAPITO CORTEZ. I wouldn't have the exact date right now but it has been more than 2 or 3 months, I guess.

Mr. PENNY. OK, for the last few months anyhow.

And prior to that what kind of employment did you have?

Mr. AGAPITO CORTEZ. I was working for Goodwill Industries.

Mr. PENNY. Same kind of situation?

Mr. AGAPITO CORTEZ. Yes. I was there, since I knew a lot about janitor work they had me teaching the other group that was coming in, with alcoholics and people that were drug addicts and things like that. I was trying to teach them a trade.

Mr. PENNY. And for the last 15 years—it has been 15 years since you had a steady permanent job?

Mr. AGAPITO CORTEZ. Well, it is always 2 or 3 years, and then the first time that it slows down, well, you know, since I miss a lot out I go.

Mr. PENNY. OK. But over a 15-year time period it has been kind of a sporadic employment history?

Mr. AGAPITO CORTEZ. Yes.

Mr. PENNY. Stretches of time when you haven't been employed at all?

Mr. AGAPITO CORTEZ. Right. Usually it takes me before I—last time I got a job with Goodwill it took me 8 months.

Mr. PENNY. Without any job at all until you got that one?

Mr. AGAPITO CORTEZ. The one at the health centers, I finally went and told them, well, either you give me a job or I am going to go out there and rob a bank and get thrown in jail, and then my family can qualify for food stamps and welfare, you know, things like that.

Mr. PENNY. During those time periods when you haven't had a job at all where did the support from the family come from?

Mr. AGAPITO CORTEZ. She works.

Mr. PENNY. You work as well?

Mrs. JUANITA CORTEZ. Yes.

Mr. AGAPITO CORTEZ. She works.

Mr. PENNY. You work now?

Mrs. JUANITA CORTEZ. I am working right now at Southside High School. I am a cook there. I work 6½ hours a day and for 9 months.

Mr. PENNY. You have been there for 9 months and you work every day except weekends?

Mrs. JUANITA CORTEZ. I work 9 months out of the year.

Mr. PENNY. Nine months out of the year. OK.

Mrs. JUANITA CORTEZ. I have been working there for 10 years.

Mr. PENNY. Oh, you have. And that brings in a little extra family cash then.

Do you grow produce on your 12-acre farm?

Mr. AGAPITO CORTEZ. No. Because there it is very dry.

Mr. PENNY. Oh, it is. And so it is mostly just a home site?

Mr. AGAPITO CORTEZ. Yes, it is.

Mr. PENNY. So you have got some land for yourself and a home for yourself.

Mr. AGAPITO CORTEZ. It is a home site. Like the older one wants to build a house, the land is there for him to build a house. He doesn't have to worry about finding a house to buy.

Mr. PENNY. You have two boys who are already out of school?

Mr. AGAPITO CORTEZ. Yes.

Mr. PENNY. They have both got their degrees.

Mr. AGAPITO CORTEZ. They have right now. One of them was supposed to have gone and I hope he got hired as a fireman.

Mr. PENNY. As a fireman?

Mr. AGAPITO CORTEZ. He did it on his own.

Mr. PENNY. And he is living in the San Antonio area?

Mr. AGAPITO CORTEZ. Yes.

Mr. PENNY. He is on his own, he is not living with you?

Mr. AGAPITO CORTEZ. He is not with us. He is on his own.

Mr. PENNY. Has he had any other job or is this his first job?

Mr. AGAPITO CORTEZ. Well, he is working for Universal Countertops. That is where he is working.

Mr. PENNY. And he is now trying to get hired as a fireman?

Mr. AGAPITO CORTEZ. Yes. Because he graduated school and he can do better than just making countertops.

Mr. PENNY. And how about the other boy?

Mr. AGAPITO CORTEZ. He is right now trying to get a job as assistant manager for Wendy's.

Mr. PENNY. How long has he been out of school?

Mr. AGAPITO CORTEZ. Well, he is 27.

Mr. PENNY. So he has been out for some time. And he has had other jobs during this time period?

Mr. AGAPITO CORTEZ. Yes.

Mr. PENNY. And he has lived on his own most of this time?

Mr. AGAPITO CORTEZ. Yes.

Mr. PENNY. So getting that high school degree did make a difference for those two?

Mr. AGAPITO CORTEZ. It did make a difference, and I am very proud of them. At least they were able to get something that I only dreamed of getting. And that is why I keep telling him, you know, to stick with it. Look at your brothers. Slow but, you know, it will come.

Mr. PENNY. And you are not on any public assistance right now?

Mr. AGAPITO CORTEZ. No.

Mr. PENNY. During the last 15 years what kind of public assistance have you received?

Mr. AGAPITO CORTEZ. The last time, it was 7 years ago that I went to the Food Stamp Program. They told me, since I had 12 acres of land and I had money to pay for that land, I had money to buy groceries.

Mr. PENNY. So the last time you checked into any public assistance was 7 years ago? How about unemployment compensation or workmen's compensation?

Mr. AGAPITO CORTEZ. Well, I got that for about 3 or 4 months—4 months, because they told me that it was running out. When you go to unemployment, they give you a piece of paper and you have to go and get at least 6 or 10 people to sign that. You go to a place of business and they are not hiring, you say, "Will you please sign here that I was here?" They say, "Well, we don't have the time."

Mr. PENNY. But you haven't been on unemployment——

Mr. AGAPITO CORTEZ. I think I just gave it up about a month ago because they told me it was running out.

Mr. PENNY. So over the last 15 years you have been on unemployment periodically?

Mr. AGAPITO CORTEZ. Off and on.

Mr. PENNY. Off and on, but not for very long stretches?

Mr. AGAPITO CORTEZ. My biggest place that I stayed the longest was the University of Mexico here in San Antonio. But since they had their problems, too, with devaluation of the Mexican money, they were forced to let me go.

Mr. PENNY. What about the food distribution program? I think we call it TEFAP, although it may be a food shelf program down your way, I am not sure. It is handled differently. It sounded to me like you have had access to that. That is where they give you cheese.

Mr. AGAPITO CORTEZ. Well, I go and bring it, see.

Ms. VALDEZ. He does our transport for us.

Mr. PENNY. You get some of that as part of your payment for handling the program?

Mr. AGAPITO CORTEZ. No, I don't get paid for that.

Ms. VALDEZ. No, no, no. Not at all.

Mr. PENNY. I mean, I wouldn't object to that. I am just asking.

Ms. VALDEZ. No.

Mr. AGAPITO CORTEZ. I do that in my own pickup truck. Because they claim they can't afford to buy a truck for that, so I do it on my own pickup truck.

Mr. PENNY. Well, do you get any of that produce yourself?

Ms. VALDEZ. He has just qualified. We just submitted an application, so he starts in April.

Mr. PENNY. He qualifies now. He is working at the center, he is helping with the distribution program, and he qualifies for some of that.

Ms. VALDEZ. Yes, he now qualifies for it.

Mr. PENNY. Are you basically getting cheese down there or do you have some bread products as well?

Ms. VALDEZ. We are getting cheese, some butter, some honey, rice, flour——

Mr. AGAPITO CORTEZ. Powdered milk.

Ms. VALDEZ [continuing]. And powdered milk.

Mr. PENNY. Can I ask, Paul, in your neighborhood is your family situation pretty typical?

Mr. PAUL CORTEZ. My neighborhood?

Mr. PENNY. Yes. The people that live in your neighborhood there, are there a lot of other families kind of in the same situation

your family is where mom and dad both work, neither maybe have the best-paying jobs around but they are somehow—or maybe there is a lot of families that are worse off in terms of no jobs at all?

Mr. PAUL CORTEZ. Well, I have a couple of friends that are certainly, where their dad is the same way and they are the same way as us. They are suffering just like us.

Mr. PENNY. What is the employment situation in the San Antonio area? I mean, is it an economy with growing job opportunities? Because I don't know Texas.

Ms. VALDEZ. Yes. It is an economy with growing job opportunities. However, they are very skilled jobs, high tech jobs, and what is happening is most of the people just don't have skills so they are not taking on these jobs.

Mr. PENNY. It was mentioned earlier I think by Rose that 60 percent of the population in your community—is it El Carmen?—didn't have high school diplomas. Are things getting better in this generation? Are we seeing more graduates in this current generation than the general population?

Ms. VALDEZ. Yes, we are. The graduating class of 1987 of Southside High School, two-thirds of them completed their education.

Mr. PENNY. So it is better but it is not a heck of a lot better?

Ms. VALDEZ. It is not wonderful; no.

Mr. PENNY. In your case, I mean you have certainly been persuaded that sticking with school is the smartest thing to do, and apparently it has helped your older brothers get into the work force, but what is happening to some of the kids that drop out? You certainly must know some that have already dropped out.

Mr. PAUL CORTEZ. Well, some.

Mr. PENNY. Where are they at? I mean, are they getting jobs? Is it really a rewarding thing for them to get out of school?

Mr. PAUL CORTEZ. Some of them just want to get out just because they don't want to go to school.

Mr. PENNY. Get out for the sake of getting out. So it isn't a given that if they drop out of school they are going to find a job and help their families?

Mr. PAUL CORTEZ. Well, they can't find a job if they drop out.

Mr. PENNY. I mean the odds are. But that would be part of the motivation for them, I would guess, though, is to help the family, and yet once they get out they may not be offering much help at all.

Can you think of anything that could be done to provide a stronger incentive for students to stay in school? I mean, what would help you to decide to stay in school besides your dad telling you that you had to?

Mr. PAUL CORTEZ. To get a degree.

Mr. PENNY. How can we reinforce that, though? I mean, how can we make an impression on the other 33 percent of these kids that are leaving school that that is not a very smart thing for them to do? What is it that we could do, or what is it that teachers could do at the school to make a better impression on these kids that it is worth it to stick with it? Tough to say?

Mr. PAUL CORTEZ. Talk to them.

Mr. PENNY. Is it better to have someone like you talk to them or can older folks have an impression on them?

Mr. PAUL CORTEZ. In a way. They probably wouldn't listen anyway.

Mr. PENNY. They may not listen anyway. But that is really, I mean, that is a tragedy when you have got that many young people leaving high school. I mean, the odds are in today's economy that without at least a high school degree you are just assigning yourself to unemployment for the rest of your life, or at least at best a sporadic employment situation. Your brothers have already proven that with that degree you have got a better chance of keeping some type of job. It may not be the best job around but at least something.

Well, I appreciate your being here. As the chairman said at the outset, this kind of testimony is more meaningful to us than all of the statistics that can be dumped on us. You know, statistics don't tell us about what is really going on out there. I mean, it is easy to depersonalize the debate when all you are looking at is numbers.

Mr. AGAPITO CORTEZ. But if they would only go and visit the schools, talk to the kids, visit the neighborhoods, and really see for themselves what is out there, and not reading them percentagewise.

Mr. PENNY. That is precisely why your being here is so valuable, because it humanizes the issue for us. I will give our chairman credit. That this is one committee that gets out of town and travels to various locations around the country to see for firsthand, and I think that is a valuable thing for us to do.

Mr. AGAPITO CORTEZ. In our opinion, too.

Mr. PENNY. We also appreciate those of you who take the time to come here.

Mr. AGAPITO CORTEZ. We, ourselves, did not have city water there, but we finally got it. Took us 20 years almost to get city water, but we got city water. It cost us a good penny. I, myself, had to pay $1,700 to tie into the main water line.

Mr. PENNY. Oh, you do?

Mr. AGAPITO CORTEZ. Yes, sir.

Mr. PENNY. That is a pretty penny.

Mr. AGAPITO CORTEZ. Everything we do is for the future of our kids.

Mr. PENNY. Well, I thank you for being here.

Mrs. JUANITA CORTEZ. Sir, going back to encouraging the kids to stay in school, I think that the kids would stay in school if they had better equipment and materials to work with. At Southside High School they don't have all the materials that they need. They need a lot of materials to work with. For instance, I think that every year it is getting harder and harder on the kids to study their studies. They had a research, not recently, maybe a month back, on English research, and to do that they needed special typewriters, they needed special books to work with, which the school didn't have. And the branches that are out there of libraries, they didn't have it, so they had to go to the main library up in town, which some families do not have the transportation to go and take the kids to that main library. So I think that if they would have the equipment to work with I think that would help them a lot.

Mr. PENNY. I appreciate that suggestion. I am on the Education and Labor Committee as well, and the issue of dropouts is some-

thing we are working with over there and trying to identify policies or types of assistance that we can provide the local school districts to help them keep these kids in school. It is again one of the valuable dimensions of this committee that it is a select committee, which allows us to look at the broad issues relating to hunger. And all of us serve on other committees like Agriculture and Education and Labor, and we can take back some of what we hear in this committee and try to incorporate that into the policies we adopt in those other committees. So I appreciate your advice in that respect.

Mrs. JUANITA CORTEZ. Yes. Because there are a lot of students there that do want to get up there; you know, to have better of everything. but if they don't have the materials to work with, how are they going to do it? I know that Paul said: "Well, I am not going to do it because I don't have, you know, the things to work with, so I am going to get a flat zero on it."

Mr. AGAPITO CORTEZ. So we got him the books. We took him out there.

Chairman LELAND. Very good.

Mr. AGAPITO CORTEZ. We had a hard time proving, so we could get a library card, because we live on a route number. If you are in the city you have a regular address. Out there two or three families get their mail in one box. We tried to prove to the library, you know.

Chairman LELAND. So you don't have an address?

Mr. AGAPITO CORTEZ. We have an address. But let's say my address is Route 7, Box 400. Also, the people in front of us is Route 7, Box 400.

Chairman LELAND. I am also the chairman of the Postal Operations Subcommittee.

Mr. AGAPITO CORTEZ. You know, everybody is going to get their mail in one box.

Chairman LELAND. You are testifying for a lot of different reasons, and we appreciate it.

Mr. AGAPITO CORTEZ. If you go to look for me, you know, you look at the map, La Soya is not on the map, so don't look at the map.

Chairman LELAND. We also understand the problem of cluster boxes, and so forth, too.

Mr. PENNY. You can't find my hometown on the map, either. [Laughter.]

Chairman LELAND. Except you ask where he is from, everybody knows where he is from.

Let me ask a few questions, if I might. And I know that the hour is late and you are anxious to leave. You have been very patient and you have been here for a long time. Are you going back to San Antonio tonight?

Ms. VALDEZ. No.

Mr. AGAPITO CORTEZ. Tomorrow.

Chairman LELAND. Tomorrow. So you will have a chance to see Washington, I hope.

Mr. AGAPITO CORTEZ. Well, we hope so.

Chairman LELAND. Well, I hope you don't leave too quickly then. Did you get a chance to tour Washington a little bit?

Mr. AGAPITO CORTEZ. No. We just got off the airplane and came straight over here.

Chairman LELAND. Is this your first trip to Washington?
Mr. AGAPITO CORTEZ. First trip to Washington.
Mr. PENNY. What time is your flight tomorrow?
Ms. VALDEZ. 5:35.
Chairman LELAND. Oh, you have got plenty of time. Very good. And you don't have to go to school, so you are happy about that, aren't you?
Mr. AGAPITO CORTEZ. I think his history teacher is going to quiz him on what he heard here.
Chairman LELAND. Certainly, if you need some assistance in getting into places and/or some advice about where to go, please feel free to call on our offices. We are very happy to be able to provide that for you. Washington is an invaluable experience. I don't know how many times you get a chance to leave Texas even, but Washington is your Nation's Capital and there are a lot of beautiful things to see. You are not going to be able to see them all in one day, but certainly you will get a chance to see a lot. We appreciate that.
Let me pursue some questions, if I can. Of your family income, your monthly income, approximately how much of that is spent on food?
Mr. AGAPITO CORTEZ. Well, there are weeks that I will sit down and spend half the night trying to think, and then my wife says: "What is the matter? You don't love me anymore. You don't pay attention to me." Say I try, you know, first from about $64, sometimes $27 because I still have to pay my bills.
Chairman LELAND. On food?
Mr. AGAPITO CORTEZ. On food. Our main diet is mostly of beans, potatoes and rice, and day-old bread.
Chairman LELAND. Beans, potatoes, and rice. And you drink a lot of water?
Mr. AGAPITO CORTEZ. And day-old bread, because day-old bread is easier to buy. We buy from H.E.B.
Chairman LELAND. You said that for 2 years you went without electricity.
Mr. AGAPITO CORTEZ. Yes.
Chairman LELAND. Was that a choice because you just didn't have the money to afford the electricity and you needed money to buy food and other things?
Mr. AGAPITO CORTEZ. Well, I was building the house at the time and I needed a septic tank system, and it cost $2,500 and they wanted cash. You know, because I didn't have credit, so I couldn't get it with credit. So we had put most of the plumbing in the house. We just made us a big hole, we covered it up, and there is where the waste went to. Then after 2 years calling City Public Service, you know, I finally got my electricity, and it only costs me $68. But the first time they said it would cost me $1,500.
So after we got our electricity, well now, you know, at least the kids can see television. Because they used to tell me every day: When, Daddy, are we going to be like the rest of the families that have a television?
Chairman LELAND. I am struck by the circumstance of your life and the vibrancy that I feel that you have about your responsibility to support your family, both you and Mrs. Cortez.

Mr. AGAPITO CORTEZ. Well, when we got married, we said "I do," and we still do. [Laughter.]

Chairman LELAND. Forever, huh? And you have five children?

Mr. AGAPITO CORTEZ. Six.

Chairman LELAND. Six children. Three boys, three girls?

Mr. AGAPITO CORTEZ. Yes.

Chairman LELAND. And you have got three away from home and three at home?

Mr. AGAPITO CORTEZ. Yes.

Chairman LELAND. Do your kids who are away from home still help you at all?

Mr. AGAPITO CORTEZ. Oh, they do, but I cannot depend on them. They have their own, you know——

Chairman LELAND. Families and other things.

Mr. AGAPITO CORTEZ. I tell them, "Look. Fellows, I need some money." Like we can make this trip over here and I told Leonard, my son, he was the only one available, "I just have $9 in my pocket."

He said: "Dad, I can only give you $20."

I said: "Give me the $20. At least we can buy a souvenir."

Chairman LELAND. Let me say to Paul—Paul, do you feel good about being able to get a job in the summer and helping your family? Are you the oldest of the children who are left at home?

Mr. PAUL CORTEZ. Yes.

Chairman LELAND. You have two?

Mr. PAUL CORTEZ. Sisters.

Chairman LELAND. Two sisters at home, and you pretty much take care of them. You look after your sisters?

I feel that you really understand the value of being in school. Did you drop out at all before?

Mr. PAUL CORTEZ. No.

Chairman LELAND. You haven't dropped out? And you expect to graduate after next year; right?

Mr. PAUL CORTEZ. Yes, sir.

Chairman LELAND. Have you ever really wanted to go to college, to community college or some other school after you have graduated from high school?

Mr. PAUL CORTEZ. Well, I want to go to a vocational college.

Chairman LELAND. So you can learn a trade or develop a skill.

Mr. PAUL CORTEZ. I am taking a class for it right now in school.

Chairman LELAND. Are you in what is called distributive education?

Mr. PAUL CORTEZ. Building trades.

Chairman LELAND. Yes, something similar. Yes. And you like that?

Mr. PAUL CORTEZ. Yes, sir.

Chairman LELAND. So you really believe now that you are going to stay in school in order that you can help your folks. Well, that is admirable. Let me say that I hope that you do. Sometimes you might find that even though you have very little, whether you have the books and the typewriters and things like that available, sometimes even if you work hard at it you can do a lot with very little, and particularly given the responsibility knowing the circumstance of your father, in particular, who has had a hard time be-

cause of his particular illness. You can go a long ways to help them.

And if we can say anything here, and I know that my colleague feels the same way, as he has said, we hope that you will be inspired at least, you know, to some extent to go on and finish school, get a degree, so that indeed you can get the kind of job that you want, something that you might have a greater opportunity facing you than what you might even imagine right now. So we are inspired by your coming here to spend some time with us.

You have a lot of responsibility on your shoulders as a young man who is in school. Not only a young man who grew up in a situation where you have a very difficult time in life, but you are also an Hispanic. Hispanics in this country have suffered a lot of problems because of poverty and because of a lack of educational opportunities. Growing up in the barrio is not the easiest thing in the world.

I grew up in the ghetto, if you will, in the barrio of the black community. My mother reared two boys by herself and had to struggle along like your mother and father did. And those two boys that my mother reared—well, she had it easier because she only had two boys. She had it a little more difficult, though, because she didn't have a husband around. But both of those boys are pharmacists and one is a Member of Congress.

But I can tell you that I am not much different—my circumstances were not much different than yours. When I was growing up I had the same kinds of problems. I never had to want for anything. We might not have been able to eat all we wanted. By the way, there were no food stamps at that time. No public assistance programs that my mother could go to get. We were fortunate in that we grew up in my grandmother's house, so therefore, we didn't have to pay any rent, but we had to pay for everything else. My mother was a short-order cook in a pharmacy, in a drugstore. She worked at night and went to school, Texas Southern University, during the day. She took us with her. We were little boys. She had started all over when I was about 7 or 8 years old. My brother was a year younger than me. She made it. We watcher her—we went to her graduation. She was very proud. And then she got two master's degrees and now she is the principal of an elementary school.

But I can only say to you, Paul, that if you work hard at it you can make it, too. You don't have to stop with just trade school. You don't have to stop at high school, that is for sure. There is a lot out there for you.

I know that your Congressman, who has shown great interest in all of you, will be glad to help you in any way that he can. Al is a great man. And he is the son of migrant workers—migrant farmers, if you will.

We appreciate your contribution today. We will have to submit some questions to you in writing, and we will keep the record open for your responses. And again, we want to make sure that you enjoy yourself, too, while you are here. Come to the office tomorrow and we will be glad to give you some guidance as to where you might want to go and provide you with some tickets and passes, if you will, to go into the Congress and see what we do. You might

get a lot more confused about what this is all about by going to see all of that.

Mr. AGAPITO CORTEZ. Well, you know, this is something similar to where we went when we were fighting to get our city water.

Chairman LELAND. Oh, yes, at city council.

Mr. AGAPITO CORTEZ. You know, we had to get in there and I mean you had to dig in there. Otherwise, they would have passed you by and you wouldn't be heard.

Chairman LELAND. I can tell that you feel very comfortable about challenging us, and that is really good. [Laughter.]

Mr. AGAPITO CORTEZ. Well, I got my experience, you know, over 15 years. At first we didn't know how to approach and how to do, and still I am a man that doesn't know how to read and write but I do understand a lot of things.

Chairman LELAND. How far did you go in school?

Mr. AGAPITO CORTEZ. Well, they just kept passing me because I was a Mexican. At that time Mexicans were not liked in the Allendale district where I used to go to school. By the time I was 16, I was in the eighth grade. So I really never did. They just kept passing me on.

Chairman LELAND. So you did go to the eighth grade.

Mr. AGAPITO CORTEZ. Yes, that is as far, seventh or eighth grade.

Chairman LELAND. That is as far as you went?

How about you, Mrs. Cortez?

Mrs. JUANITA CORTEZ. I went up to the ninth grade and then I had to quit school to help my family. I went to work. But then about, it has been about maybe 5 years ago that I got my GED.

Chairman LELAND. Five years ago?

Mrs. JUANITA CORTEZ. Yes.

Chairman LELAND. That is incredible.

Mrs. JUANITA CORTEZ. I think it has been about 5 years.

Chairman LELAND. That is incredible. So you don't have any problems reading and writing?

Mrs. JUANITA CORTEZ. Well, I still don't understand, you know, big words. I have to get my dictionary out. But I did accomplish a lot by getting my GED. I merely went to get it because I wanted him to get it. See he went for the GED, too. But he didn't pass it and I did.

Chairman LELAND. But he did take the test?

Mr. AGAPITO CORTEZ. No, I never got as far as the test. Every time that I would try and concentrate I would start having problems with my epilepsy, so I just gave it up.

Chairman LELAND. Your concentration sometimes causes the seizures? Well, that is a change.

Mrs. JUANITA CORTEZ. So I got to know what it is to walk down the aisle besides the aisle of marriage.

Chairman LELAND. Well, that must be a source of pride for your family.

Mrs. JUANITA CORTEZ. Yes.

Mr. AGAPITO CORTEZ. Well, she is the one that writes the checks. I just try to get the money in there. [Laughter.]

And every time we go buy something, both of us sit down and discuss it—well, what do you think—you know.

Mrs. JUANITA CORTEZ. Don't do no more.

Mr. AGAPITO CORTEZ. Don't do no more. I will tell her when I think it is enough, no more. We do share all of our problems. We have to sit down and discuss it. We do get angry at each other because, I mean, you know, every family gets to a point. But either she steps out or I step out, then we cool off and we get after it again, so we can iron out things together.

Chairman LELAND. USDA, the people who you heard from—the Assistant Secretary, Mr. Bode, you heard him testify today. His organization, his agency is talking about stopping the distribution of honey and rice. Do you get honey and rice—I know you don't, but——

Mr. AGAPITO CORTEZ. Well, they do get some. Not all the time. When I go to pick up the commodities, I don't know what I am getting.

Chairman LELAND. I understand. But you know how valuable that is to the people who get that, how helpful that is.

Mr. AGAPITO CORTEZ. It is. If you have nothing to eat but bread and honey, it tastes good. If you are hungry and got nothing else to eat.

Chairman LELAND. Well, they are talking about stopping the honey and rice after this month.

Mr. AGAPITO CORTEZ. Well, I don't see how could they stop it because, you know, that could mean—I don't see that very much, but once in a while.

Chairman LELAND. Well, they are also talking about not having any dry milk after May and no cheese after June. What is going to happen to those people who are not going to be able to get that food?

Ms. VALDEZ. They are going to lynch their socialworkers if that is going to happen.

Mr. AGAPITO CORTEZ. They almost did that last time.

Ms. VALDEZ. They almost did that last time.

Chairman LELAND. They think it is your fault.

Ms. VALDEZ. Yes.

Mr. AGAPITO CORTEZ. They will tell me: " Well, why didn't you bring it?" They will get on me. Say, "Probably you left it someplace else."

Chairman LELAND. Or you take it home, huh? [Laughter.]

Mr. AGAPITO CORTEZ. You know, I only have a small pickup truck and whatever they give me, my truck is always overloaded. I only got stopped once by the highway patrolman, but since I explained the situation, he says, "OK, be on your way but next time don't overload." But if I do, say, leave a case of cheese, that means there are six families out there that don't get cheese. So I try to pack whatever I can on the truck. I mean, all of it, and just tie it down the best way I can and take off. It is an old truck but it gets me where I am going. Just take it easy with an old truck, it will go. It is better than the new ones that are coming out.

Chairman LELAND. You have been absolutely wonderful. Thank you very much for your testimony.

Mr. AGAPITO CORTEZ. I appreciate your listening to us, and I hope you all can, you know, try and do something. I know this cannot be done overnight, but, you know, for the future of the kids.

Chairman LELAND. Well, let me tell you that when Paul is 48 years old, at some point in the future people in the Congress are going to look back at these records that we are compiling today and see your testimony and try to continue to do what we can, those who will be there—maybe it is Paul, himself—to see what he or she can do to help save the situation. This history is all about that we develop. Not to say that we are not going to try immediately to solve the problem. There are many problems that confront us today, budgetary interests and so forth, but in the long-term what you do here, what you have done here today will help us tremendously to sort out all of those problems. Postal problems, education problems—all of those problems.

Mr. AGAPITO CORTEZ. Well, that is the reason I always say that people ought to go and visit the communities.

Chairman LELAND. And we will. We have seen communities like yours, believe me.

Mr. AGAPITO CORTEZ. Get in there and mingle with the kids, and sit in there and listen to what they have to say. Because, you know, sometimes we don't understand the pressure they have, themselves, in the school system.

Chairman LELAND. Comprendo. Muchisimo gracias.

Mr. AGAPITO CORTEZ. Muchas gracias por la ayudar.

Chairman LELAND. Hasta luego.

Ms. VALDEZ. Mr. Leland, before we go, I have a brief by Dr. Urby on the hunger emergency.

Chairman LELAND. Is Dr. Urby here?

Ms. VALDEZ. No, he is not. He was not able to.

Chairman LELAND. He didn't come. OK. We will be glad, without objection, to enter Dr. Urby's brief into the record. Thank you very much.

[Whereupon, at 5:30 p.m., the select committee was adjourned, to reconvene subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

Prepared Statement of Hon. Bill Emerson, a Representative in Congress From the State of Missouri

A NATION'S FUTURE LIES WITH ITS CHILDREN. THUS, THE HEALTH OF OUR NATION IS A MATTER OF FUNDAMENTAL IMPORTANCE TO ALL SOCIETIES.

TODAY, THE SELECT COMMITTEE ON HUNGER WILL HEAR TESTIMONY CONCERNING THE NEEDS OF THE HISPANIC COMMUNITY. THERE IS MUCH TO SAY AND HEAR ABOUT THE ISSUES AND THE NEED FOR MORE ACCURATE DATA COLLECTION. THE HEARING THIS AFTERNOON WILL FOCUS ON WHAT WE DO KNOW AND WHAT WE SHOULD KNOW ABOUT THE HEALTH STATUS OF OUR HISPANIC AMERICANS. AS WITH ANYTHING, BECOMING AWARE OF THE PROBLEM IS THE FIRST STEP TOWARD FINDING THE SOLUTION.

EVIDENCE SUGGESTS THAT THE INFANT MORTALITY RATE IS HIGHER AMONG THE HISPANIC POPULATION. SINCE THE INFANT MORTALITY RATE HAS LONG BEEN A PRIMARY INDICATOR OF OUR NATION'S OVERALL HEALTH STATUS, IT IS EXTREMELY IMPORTANT THAT IT CONTINUE IN ITS DECLINE. FIRST, IT TENDS TO BE CLOSELY ASSOCIATED WITH ACCESS TO FOOD, SHELTER, EDUCATION, AND HEALTH CARE. SECONDLY, IT'S RELATIVELY EASY TO MONITOR WITH BASIC VITAL STATISTICS. THE U.S. INFANT MORTALITY RATE, HAS DECLINED AND THE MORTALITY RATE OF CHILDREN BETWEEN 1 AND 14 YEARS HAS ALSO DECREASED. ONE CANNOT DISMISS THE THE IMPORTANCE OF THESE GAINS.

SIMILARLY, THE ABILITY TO MAKE INFORMED DECISIONS PLAYS A SIGNIFICANT ROLE IN INFLUENCING THE OVERALL HEALTH STATUS OF AMERICANS. HEALTH EDUCATION HAS BEEN AN EFFECTIVE TOOL IN INCREASING PUBLIC AWARENESS ABOUT ACTIONS INDIVIDUALS AND COMMUNITIES CAN TAKE TO ENHANCE PERSONAL HEALTH. EVIDENCE HAS SHOWN THAT NUTRITIONAL

EDUCATION IS EFFECTIVE IN REDUCING THE COST OF HEALTH CARE. FOR INSTANCE, THE TREATMENT OF DIABETES -- WHICH HAS BEEN ESTIMATED TO BE OF HIGH INCIDENCE AMONG HISPANICS -- HAS IMPROVED THROUGH SELF-MANAGEMENT SKILLS BROUGHT ABOUT DUE TO NUTRITIONAL EDUCATION PROGRAMS. THESE PROGRAMS ARE PARTICULARLY CRITICAL AND NEEDED WHERE THE IMPACT ON HEALTH IS GREATEST, ESPECIALLY WITH DIABETES, OBESITY AND HEART DISEASE, ALL VERY PREVALENT AMONG HISPANIC AMERICANS.

FURTHER, THE FOOD AND NUTRITION SERVICE BRANCH OF USDA IN COOPERATION WITH STATE AND LOCAL GOVERNMENTS, PROVIDES FOOD ASSISTANCE AND NUTRITIONAL EDUCATION FOR THOSE IN NEED. THESE PROGRAMS WERE CREATED TO IMPROVE THE NUTRITION OF LOW-INCOME HOUSEHOLDS WHILE CREATING A MEANS BY WHICH TO IMPROVE NUTRITIONAL KNOWLEDGE.

I AM PLEASED THAT THE SELECT COMMITTEE ON HUNGER IS HOLDING A HEARING ON THE IMPORTANT SUBJECT OF THE NEEDS OF THE HISPANIC POPULATION. I LOOK FORWARD TO HEARING THE TESTIMONY FROM OUR WITNESSES AND THEIR ASSESSMENT OF HOW THESE NEEDS CAN BEST BE MET.

Prepared Statement of Hon. Bill Richardson, a Representative in Congress From the State of New Mexico

MR. CHAIRMAN, AND MEMBERS OF THE COMMITTEE, THANK YOU FOR THE OPPORTUNITY TO ADDRESS A CRITICAL ISSUE FOR MY DISTRICT AND THE HISPANIC COMMUNITY IN GENERAL -- THE LACK OF HEALTH DATA ON THE HISPANIC COMMUNITY, SPECIFICALLY AS IT RELATES TO HISPANICS IN THE HEALTH PROFESSIONS.

THE QUALITY OF HISPANIC HEALTH DATA IN GENERAL IS ABYSMAL. WE DO NOT KNOW THE HEALTH STATUS OF THE HISPANIC COMMUNITY, EITHER IN COMPARISON TO OTHER SEGMENTS OF THE POPULATION, OR FOR DIFFERENT TIME FRAMES. WITHOUT SUCH INFORMATION, HEALTH PLANNING BECOMES IMPOSSIBLE. FURTHERMORE, WE DO A GREAT DISSERVICE TO THE HISPANIC COMMUNITY.

THE HARD FOUGHT FOR HISPANIC SAMPLE IN THE HEALTH AND NUTRITION EXAMINATION SURVEY OF 1982 PROVIDED US WITH THE FIRST PICTURE OF THE HEALTH OF THE HISPANIC COMMUNITY. HOWEVER, FOR A NUMBER OF REASONS, THIS SAMPLE ONLY GAVE US A LIMITED VIEW OF THE HEALTH OF THE HISPANIC COMMUNITY. FIRST, THE SAMPLE DID NOT COMPARE HISPANICS TO OTHER GROUPS IN THE POPULATION. SECONDLY, BECAUSE IT WAS A ONE TIME SAMPLE, IT DOES NOT PROVIDE A TIME CONTINUUM. THEREFORE WE CANNOT DETERMINE WHETHER THE HISPANIC COMMUNITY'S HEALTH IS IMPROVING OR WORSENING.

I AM PARTICULARLY CONCERNED WITH THE LACK OF DATA ON THE HEALTH NEEDS OF THE HISPANIC COMMUNITY. WE DO NOT KNOW THE EXTENT OR NATURE OF OUR OWN HEALTH PROBLEMS. WE DO NOT KNOW THE NUMBER OF HISPANIC DOCTORS, NURSES, OR OTHER ALLIED HEALTH PROFESSIONALS OR WHETHER THEY ARE SERVING THE HISPANIC COMMUNITY OR OTHER COMMUNITIES. WE FRANKLY DON'T KNOW WHAT THE HISPANIC COMMUNITY NEEDS NOR WHO IS FILLING THAT NEED.

AS A RESULT, I AM INTRODUCING LEGISLATION TO ADDRESS THE NEED FOR HEALTH PROFESSIONALS TO DELIVER APPROPRIATE CARE TO THE HISPANIC COMMUNITY. ONE OF THE MAJOR LIMITATIONS IN PREPARING THIS LEGISLATION HAS BEEN THE LACK OF DATA CONCERNING THE SPECIFIC HEALTH PROFESSIONAL NEEDS OF THE HISPANIC COMMUNITY. IT HAS BEEN ESPECIALLY DIFFICULT TO DETERMINE THE EXTENT OF THE NEED FOR HEALTH PROFESSIONALS DELIVERING CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE TO THE HISPANIC COMMUNITY.

FOR THIS REASON, MY LEGISLATION NOT ONLY SEEKS TO INCREASE THE NUMBER OF HISPANIC PHYSICIANS PRACTICING IN MEDICALLY UNDERSERVED HISPANIC COMMUNITIES BUT ALSO PROVIDES FOR AN ANALYSIS OF THE HEALTH PROFESSIONAL NEEDS OF THE COMMUNITY.

IT IS MY FIRM BELIEF THAT THE REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PERSONNEL IN THE UNITED STATES, AS MANDATED BY SECTION 708 OF THE PUBLIC HEALTH SERVICE ACT SHOULD CONTAIN THIS TYPE OF INFORMATION SO THAT HEALTH PLANNERS CAN EVALUATE THE HISPANIC COMMUNITY'S CURRENT AND PROJECTED NEED FOR HEALTH PROFESSIONALS, AND MORE EFFECTIVELY ALLOCATE EXISTING HEALTH PROFESSIONAL RESOURCES AMONG HISPANIC COMMUNITIES.

SUCH IS NOT THE CASE. THE LATEST REPORT, ISSUED IN 1986, CONTAINS NO INFORMATION ON THE NEED FOR HEALTH PROFESSIONALS IN THE HISPANIC COMMUNITY BY SPECIALTY OR GEOGRAPHIC LOCATION. THE ONLY INFORMATION ABOUT HISPANICS IN THIS REPORT IS A MINOR INCLUSION ON HISPANIC ENROLLMENT IN MEDICAL SCHOOLS AND SCHOOLS OF OSTEOPATHY AND DENTISTRY. MY LEGISLATION WOULD ASSURE THAT CRITICAL INFORMATION BY BOTH SPECIALTY AND GEOGRAPHIC LOCATION WOULD BE INCLUDED FOR HISPANICS AND FOR OTHER MINORITY GROUPS IN THE REPORT ON THE STATUS OF HEALTH PERSONNEL.

IN CLOSING, I AM CONFIDENT THIS HEARING WILL SHED LIGHT ON THE UBIQUITOUS DISREGARD OF THE HISPANIC COMMUNITY THROUGHOUT OUR NATIONAL HEALTH DATA COLLECTION AND ANALYSIS SYSTEMS. I BELIEVE THIS ATTITUDE IS THE MAJOR CONTRIBUTING FACTOR TO THE CURRENT LACK OF HEALTH SERVICES FOR THE HISPANIC COMMUNITY. FURTHERMORE, IT DEMANDS IMMEDIATE ATTENTION. I APPLAUD THE LEADERSHIP OF THIS COMMITTEE FOR BRINGING LIGHT TO AN ISSUE WHICH HAS BEEN DARK FOR TOO LONG.

Prepared Statement of Hon. Albert G. Bustamante, a Representative in Congress From the State of Texas

MR CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO TESTIFY BEFORE THIS COMMITTEE ON THE HEALTH AND NUTRITION OF HISPANICS.

I WOULD LIKE TO TAKE A FEW, BRIEF MOMENTS TO RECOGNIZE SEVERAL INDIVIDUALS AND THANK THEM FOR THEIR CONTRIBUTION TO THIS HEARING.

I WOULD LIKE TO THANK MY CONSTITUENTS, THE CORTEZ FAMILY OF SAN ANTONIO, TEXAS, FOR AGREEING TO SHARE THEIR LIFE EXPERIENCES WITH THIS COMMITTEE.

I WISH TO EXPRESS MY APPRECIATION FOR DR. URBY'S SUBMISSION OF WRITTEN TESTIMONY ON HISPANIC HEALTH AND POVERTY. DR. URBY IS THE DIRECTOR OF THE "EL CARMEN CLINIC." HE TOOK TIME OUT OF HIS BUSY SCHEDULE TO PUT INTO WORDS HIS INSIGHTS ON THE HEALTH PROBLEMS OF LOW-INCOME, HISPANIC PATIENTS HE TREATS DAILY IN SAN ANTONIO.

ALSO, I WOULD LIKE TO THANK ROSE VALDEZ, FOR HER INPUT INTO THE OVERALL SITUATION OF THE CORTEZ FAMILY, AS THEIR DEDICATED AND KNOWLEDGEABLE SOCIAL WORKER. EACH OF THESE INDIVIDUALS' TESTIMONY WILL ASSIST THIS COMMITTEE TO GAUGE THE SEVERITY OF THE PROBLEMS WE ARE HERE TO ADDRESS.

I WOULD LIKE TO BEGIN TODAY BY PROVIDING THIS COMMITTEE WITH A BRIEF SOCIAL PROFILE OF HISPANIC AMERICANS, THEN PROCEED TO EXPLORE PREVELENT HEALTH PROBLEMS THAT EXIST IN THIS ENVIRONMENT. MOST OF THE STATISTICAL INFORMATION I WILL PROVIDE HAS BEEN RETRIEVED FROM TWO SOURCES: ONE,"THE TASK FORCE REPORT ON BLACK AND MINORITY HEALTH OF THE SECRETARY OF HEALTH AND HUMAN SERVICES"; AND TWO, "THE AGING SOCIETY PROJECT, HISPANICS IN AN AGING SOCIETY."

IN 1987, THERE WERE APPROXIMATELY 18.79 MILLION HISPANICS IN THE UNITED STATES. THIS CONSTITUTES 7.9 PERCENT OF THE TOTAL U.S. POPULATION. MEXICAN AMERICANS COMPOSE 66 PERCENT OF THAT HISPANIC POPULATION. SINCE 1970, THE HISPANIC POPULATION HAS GROWN BY OVER 60 PERCENT, CONTRIBUTING TO 23 PERCENT OF THE TOTAL GROWTH OF THE U.S. POPULATION FROM 1970 TO 1980.

THE HISPANIC POPULATION IS EXPECTED TO CONTINUE THIS HIGH RATE OF GROWTH BECAUSE OF TWO DEMOGRAPHIC FACTORS. FIRST, THE HISPANIC POPULATION IS YOUNG AS COMPARED WITH THE GENERAL POPULATION. A LARGE SHARE OF THE HISPANIC FEMALE POPULATION IS CURRENTLY EITHER UNDER AGE 15 OR IN THE REPRODUCTIVE YEARS OF AGES 15 TO 44. THIS YOUNG MEDIAN AGE CONTRIBUTES TO THE HIGH FERTILITY RATE OF HISPANICS, WHICH IS EXPECTED TO CONTINUE WELL INTO THIS CENTURY.

SECOND, THE IMMIGRATION OF THIS POPULATION INTO THE UNITED STATES IS EXPECTED TO CONTINUE AT HIGH RATES DUE TO THE UNCERTAIN ECONOMIC AND SOCIAL SITUATIONS OF MANY LATIN AMERICAN COUNTRIES.

DESPITE THEIR INCREASING NUMBERS, HISPANICS HAVE NOT BENEFITED FULLY FROM MEDICAL ADVANCES MADE IN THE LAST 50 YEARS. TODAY, MINORITIES IN THE UNITED STATES CONTINUE TO EXPERIENCE A GREATER INCIDENCE OF MANY DISEASES -- INCLUDING

GALLBLADDER CANCER, TAY-SACHS DISEASE AND SICKLE-CELL ANEMIA -- THAN DOES THE GENERAL POPULATION. ESPECIALLY DISTURBING IS THE HIGH INCIDENCE OF DIABETES AND DIABETES RELATED ILLNESSES.

ACCORDING TO THE REPORT ON MINORITY HEALTH, THERE EXISTS A PERSISTANT DISPARITY "IN THE BURDEN OF DEATH AND ILLNESS EXPERIENCED BY MINORITY AMERICANS AS COMPARED WITH OUR NATION'S POPULATION AS A WHOLE." THE REPORT STATES FOUR SOCIAL CHARACTERISTICS WHICH ARE BELIEVED TO SIGNIFICANTLY INFLUENCE MINORITY HEALTH STATUS IN THE UNITED STATES TODAY:

ONE, DEMOGRAPHIC PROFILES; TWO, NUTRITIONAL STATUS AND DIETARY PRACTICES; THREE, ENVIRONMENTAL AND OCCUPATIONAL EXPOSURES; AND FOUR, STRESS AND COPING PATTERNS.

A GENERAL PROFILE OF THESE FACTORS IS NECESSARY TO UNDERSTAND HOW EACH OF THEM AFFECTS HISPANICS. BEFORE I UNDERTAKE THIS PROFILE, HOWEVER, I WOULD LIKE TO EMPHASIZE HOW INSUFFICIENT HEALTH DATA ONLY MAKES IT DOUBLY DIFFICULT TO RESOLVE THE HEALTH PROBLEMS OF HISPANICS.

ONE PROBLEM IS THAT THERE ARE NO STANDARD PRACTICES USED BY ALL THE STATES FOR INCLUDING ETHNICITY IDENTIFIERS IN REPORTED DATA. ONE OF THE MOST GLARING DEFICIENCIES IS THE LACK OF NATIONAL MORTALITY DATA FOR HISPANICS. SUCH DATA IS USUSALLY OBTAINED FROM DEATH CERTIFICATES; BUT FOR HISPANICS, ETHNICITY IS NOT UNIFORMLY RECORDED IN EVERY STATE. IT SHOULD ALSO BE NOTED THAT MORTALITY DATA IS USUALLY NOT RECORDED FOR SUBGROUPS OF NATIVE AMERICAN AND ASIAN/PACIFIC HERITAGE.

FURTHERMORE, FEDERAL IDENTIFIERS THAT ARE REQUIRED BY OMB CLASSIFY RACE AS FOLLOWS:

1. AMERICAN INDIAN OR ALASKAN NATIVE
2. ASIAN OR PACIFIC ISLANDER
3. BLACK
4. WHITE

ETHNICITY IS DEFINED AS: OF HISPANIC ORIGIN, OR, NOT OF HISPANIC ORIGIN.

THESE CATAGORIES ARE TOO GENERAL TO PERMIT DELINEATION WITHIN SUBGROUPS. MANY STATISTICAL FILES AND DATA BASES FALL SHORT OF MEETING EVEN THESE REQUIREMENTS, PARTICULARLY ADMINISTRATIVE RECORDS, SELF-REPORTED HOSPITAL FORMS, AND SOME SOCIAL SECURITY CLAIMS. EVEN WHEN A MORE SPECIFIC BREAKDOWN OF RACE AND ETHNICITY IS USED, THE INFORMATION MAY EVENTUALLY BE LUMPED TOGETHER AS "OTHER". THIS HAS MINIMAL IF ANY VALUE TO HEALTH RESEARCHERS, WHO ARE IN CONSTANT NEED OF ADDITIONAL DEMOGRAPHIC DATA.

ANOTHER CONCERN IS THAT DATA COLLECTED FROM NATIONAL SURVEYS USUALLY MEASURE MINORITIES IN PROPORTION TO THEIR PRESENCE IN THE U.S. POPULATION. THEREFORE, THE LESS NUMEROUS A MINORITY GROUP IS, THE LESS INFORMATION THERE WILL BE AVAILABLE ON THEM.

ONE OF THE SPECIAL NEEDS OF HEALTH SCIENTISTS IS INFORMATION

WHY IS THERE SUCH DISPARITY IN EDUCATION LEVELS?

ONE REASON MY BE DUE TO THE TYPICAL SIZE AND INCOME OF HISPANIC FAMILIES. HISPANIC FAMILIES AVERAGED 3.85 PERSONS. MEXICAN-AMERICAN FAMILIES WERE FOUND AMONG THE LARGEST, AVERAGING 4.09 PERSONS. THIRTY PERCENT OF ALL HISPANICS WERE LIVING BELOW THE OFFICIAL POVERTY LEVEL IN 1982, AND 13.8 PERCENT WERE UNEMPLOYED. IN THE LAST 10 YEARS, THE INCOME AND POVERTY LEVELS OF HISPANICS HAVE GOTTEN WORSE. IN TEXAS, WHERE OVER 20 PERCENT OF THE POPULATION IS MEXICAN AMERICAN, CLOSE TO ONE-HALF OF THE POPULATION AGE 55 AND OLDER ARE AT THE 125 PERCENT POVERTY LEVEL.

DUE TO THESE TYPICALLY LARGE FAMILIES AND THE SMALL AMOUNT OF INCOME COMING INTO THE HOUSEHOLD FOR ESSENTIALS, MANY YOUNGSTERS, AND IN SOME CASES, PRETEENS, DECIDE THAT IT IS BETTER FOR THE FAMILIY IF THEY DROP-OUT OF SCHOOL TO HELP OUT FINANCIALLY. EVEN AT THE FAMILY'S URGING THAT THEIR CHILDREN STAY IN SCHOOL, HISPANIC YOUTH BELIEVE IT IS BETTER TO HELP THEIR FAMILIES FINANCIALLY THAN REMAIN IN SCHOOL. HOWEVER, IT IS GENERALLY ACCEPTED THAT WITHOUT A HIGH SCHOOL DIPLOMA, IT IS NEARLY IMPOSSIBLE TO OBTAIN WORK WHICH OFFERS JOB SECURITY AND EARNINGS ABOVE MINIMUM WAGE. THIS IN TURN FOSTERS ANOTHER GENERATION OF UNDEREDUCATED, UNDEREMPLOYED HISPANICS.

A TRULY UNIQUE AND DIFFUCULT LIFE-SITUATION IS CREATED HERE. ONE OF STRESS AND ANGER. THIS UNIQUE PATTERN OF EXPOSURE TO STRESS AND THE WAYS OF DEALING WITH THE STRESS AND ADVERSITY IN MINORITY GROUPS MAY PLAY A CRUCIAL ROLE IN HISPANIC AND MINORITY HEALTH. IT HAS BEEN SUGGESTED THAT "THE WAYS AN INDIVIDUAL COPES WITH STRESS AND THE RESOURCES AVAILABE TO RESOLVE STRESSFUL SITUATIONS, RATHER THAN THE STRESSOR ITSELF, PLAY THE MORE IMPORTANT ROLE IN HEALTH OUTCOME. IN SOME MINORITIES, TRADITIONAL FOLK BELIEFS AND CULTURALLY SPECIFIC FAMILY PATTERNS MAY AFFECT THEIR ABILITY TO WITHSTAND SOCIAL, ECONOMIC, AND PSYCHOLOGICAL STRESSORS."

WHERE SUFFICIENT DATA IS AVAILABLE, WE SEE MINORITIES MAY HAVE PROBLEMS DEALING WITH STRESS. TAKE FOR EXAMPLE ALCOHOL ABUSE. IT'S STRONGLY SUSPECTED THAT ALCOHOL ABUSE IS ONE OF THE LEADING CONTRIBUTORS TO THE HEALTH DISPARITY IN HISPANICS, BUT WE SIMPLY DO NOT HAVE THE DATA TO VERIFY THAT SUSPICION. WHAT DATA DOES EXIST COMES FROM A FEW STUDIES IN THE SOUTHWEST.

ACCORDING TO HHS, HISPANICS ARE OVERREPRESENTED IN THE MORTALITY STATISTICS FOR ALCOHOL-RELATED CAUSES. STILL, AS HHS HAS REPORTED, "LITTLE IS KNOWN ABOUT THE HEALTH CONSEQUENCES OF ALCOHOL USE AMONG HISPANICS IN THE REST OF THE U.S." THAT'S WHY I APPLAUD YOUR EFFORTS, MR. CHAIRMAN, TO REQUEST MORE DATA ABOUT HISPANIC HEALTH AND NUTRITION. SUCH INFORMATION IS NECESSARY IF WE ARE TO DEVELOP A NATIONAL POLICY ON MINORITY HEALTH.

DRUG ABUSE HAS BEEN ANOTHER HEALTH PROBLEM IDENTIFIED AMONG HISPANICS. THE INABILITY TO OVERCOME SOCIAL PRESSURES GIVES RISE TO UNHEALTHY BEHAVIOR SUCH AS DRUG ABUSE.

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DRUG ADDICTION IS A HISPANIC RESPONSE TO "ACCULTURATION." THIS TERM IS USED BY HEALTH SCIENTISTS TO REFER TO THE PERSONAL AND FAMILY STRESSES ARISING FROM THE CONFLICT BETWEEN TWO OR MORE COMPETING CULTURAL VALUES WITHIN A SINGLE, LARGE COMMUNITY.

FOR HISPANIC AMERICANS, THE CENTRAL CONFLICT AT ISSUE IS THE CLASH OF ANGLO-AMERICAN CULTURE WITH HISPANIC CULTURE, THE FORMER TRACING ITS ORIGINS TO THE INDUSTRIAL REVOLUTION OF LATE 18TH CENTURY ENGLAND, WHILE THE LATTER HAS ITS ROOTS IN THE AGRARIAN CULTURE OF THE NON-DEVELOPED THIRD WORLD.

TO NON-HISPANICS, IT MAY SEEM A TRIFLE BIT STRANGE, IF NOT INCOMPREHENSIBLE, TO SEE HOW A MERE CULTURAL CLASH CAN GIVE RISE TO SUCH UNHEALTHY BEHAVIORS AS DRUG ADDICTION. BUT TO A FORMER MIGRANT FROM SOUTH TEXAS, LIKE MYSELF, IT COMES AS NO SURPRISE TO SEE HOW THAT CONFLICT CAN TAKE SUCH A DREADFUL TOLL OVER THE HISPANIC COMMUNITY.

TO BEST UNDERSTAND HOW "ACCULTURATION" WORKS IN PRACTICE, I WOULD LIKE TO SAY A BRIEF WORD ABOUT "INHALATION" ABUSE AMONG HISPANICS.

IN THE TECHNICAL LITERATURE, INHALATION IS DEFINED AS "THE DELIBERATE INHALATION OF VOLATILE SOLVENTS, SUCH AS GLUE, LIGHTER FLUID, AND GASOLINE." THIS PROBLEM IS PARTICULARLY SERIOUS AMONG MEXICAN AMERICAN ADOLESCENTS.

FOR EXAMPLE, "A 1979 STUDY OF MEXICAN AMERICAN CHILDREN AND ADOLESCENTS IN LOS ANGELES BARRIOS FOUND PREVALENCE OF INHALANTS 14 TIMES THAT OF THE GENERAL POPULATION."
WHAT COULD POSSIBLY DRIVE SO MANY ADOLESCENT HISPANICS TO INHALE CHEMICALS WITH SUCH POTENTIALLY LETHAL EFFECTS?

AN ANSWER TO THAT QUESTION IS HINTED AT IN A RECENT STUDY OF INHALANT ABUSE CONDUCTED BY BONNHEIM AND KORMAN, "FAMILY INTERACTION AND ACCULTURATION IN MEXICAN AMERICAN INHALANT USERS." FOR THIS STUDY, TWO SETS OF TEN FAMILIES WERE INTERVIEWED; ONE SET WITH A CHILD INHALANT ABUSER IN EACH FAMILY, AND THE OTHER; WITH A NON-INHALANT ABUSER. EACH OF THESE TWO SETS OF FAMILIES WERE "MATCHED ON ETHNICITY, INCOME AND AGE OF CHILD."

THE STUDY SHOWED HOW AN INHALANT CHILD STRUGGLES TO COPE WITH THE EXTERNAL SOCIAL ENVIRONMENT, WHERE -- BE IT BECAUSE OF PREJUDICE OR BIAS -- HE FINDS HIMSELF SHUT OUT FROM ANGLO-AMERICAN CULTURE. TURNING TO HIS FAMILY FOR REASSURANCE, THE RESEARCHERS FOUND THAT THE CHILD OFTEN FINDS HIMSELF ONLY MORE CONFUSED BY THE MALADAPTIVE BEHAVIORS OF OTHER FAMILY MEMBERS. MOST OF THESE FAMILY MEMBERS, PARTICULARLY THE PARENTS, ALSO FIND IT DIFFICULT TO ADJUST TO WHAT THEY PERCEIVE AS AN ALIEN CULTURAL ENVIRONMENT. INCIDENTALLY, I SHOULD NOTE THAT THIS IS ESPECIALLY TRUE OF RECENT IMMIGRANT FAMILIES. OUT OF DISPAIR, THE CHILD TURNS TO INHALING EASILY ACQUIRED BUT HARMFUL SUBSTANCES, WHICH ONLY SERVE TO IMPAIR HIS HEALTH AND TO ACCELERATE THE DISINTEGRATION OF HIS FAMILY'S EMOTIONAL STABILITY.

BY COMPARISON, FAMILIES WITH NON-INHALANT ABUSERS WERE FOUND TO EXERCISE MORE COOPERATION IN COPING WITH STRESS. THESE FAMILIES WERE MORE UNITED AND SUPPORTIVE OF INDIVIDUAL FAMILY MEMBERS UNDER STRESS. THEY EXHIBITED AN ABILITY TO COMMUNICATE "THROUGH EFFECTIVE USE OF HUMOR, WHICH SEEMED MORE CONSTRUCTIVE THAN THE USE OF CRITICISM BY" MEMBERS OF THE FAMILIES WITH INHALANT ABUSERS. BY WAY OF CONCLUSION, THE RESEARCHERS CONCLUDED THAT "ONE MIGHT REASON THAT THE MORE DISSIMILAR AN INDIVIDUAL OR FAMILY IS FROM THE DOMINANT CULTURE IN WHICH THEY LIVE, THE GREATER THE STRESS IN ATTEMPTING TO COPE EFFICIENTLY WITH THE DOMINANT SOCIETY."

ALTHOUGH I AM NOT READY AT THIS POINT IN MY LIFE TO TRADE MY CARRER AS LEGISLATOR FOR THAT OF SOCIAL SCIENTIST, I THINK WE WILL AGREE THAT THE NOTION THAT HISPANICS, WITH STRONG CULTURAL VALUES BASED ON THEIR HISPANIC HERITAGE, HAVE TROUBLE ADJUSTING TO ANGLO-AMERICAN CULTURE, PROBABLY COMES AS NO SURPRISE TO MOST OF US. WHAT PROBABLY DOES COME AS A SURPRISE IS HOW DEVASTATING THAT CULTURAL CONFLICT CAN BE ON THE HISPANIC PYSCHE. IT CAN DESTROY A FAMILY AND LEAD AN ADOLESCENT TO DRUG ADDICTION. AND NO MATTER HOW ILLUMINATING SCIENCE CAN BE ABOUT SUCH SAD FACTS OF LIFE, THERE IS NO GETTING OVER OUR PAINFULLY SUBJECTIVE RESPONSE TO A "BRAIN-DEAD" ADOLESCENT AND GASOLINE INHALER.

ONE RECENT HEALTH PROBLEM THAT STEMS FROM DRUG ABUSE IS AIDS. HISPANICS ACCOUNT FOR 14 PERCENT OF ALL REPORTED CASES OF AIDS. THIS IS LARGELY BECAUSE HISPANICS CONSTITUTE 10.8 PERCENT OF INNER CITY POPULATIONS. "URBAN AREAS HAVE RECORDED A CONCENTRATED DRUG ABUSE PROBLEM, INDICATING THAT HISPANICS MAY BE AT SOMEWHAT GREATER RISK OF DRUG ABUSE AND ITS CONSEQUENCES," HHS REPORTS.

THE 1984 DRUG ABUSE WARNING NETWORK DATA ALSO SHOW THAT "42 PERCENT OF HISPANICS AS COMPARED WITH 40 PERCENT OF WHITES ADMINISTER COCAINE BY INJECTION." THIS DATA IS SUGGESTIVE OF THE GENERAL TENDENCY OF HISPANIC DRUG ADDICTS TOWARD INTRAVENOUS DRUG ABUSE.

INTRAVENOUS DRUG ABUSE, THROUGH THE SHARING OF "DIRTY NEEDLES," IS ONE OF THE MAJOR FORMS OF EXPOSURE TO AIDS, WHICH EXPLAINS THE HIGH INCIDENCE OF THE DISEASE AMONG HISPANICS.

IT IS PREVELENTLY KNOWN THAT NUTRITION PLAYS A MAJOR ROLE IN OUR HEALTH. HISPANICS GENERALLY RELY ON BEANS, GRAINS AND OTHER STARCHES. IT IS NOT SURPRISING THAT THIS HIGH CALORIC DIET LEADS TO OBESITY AMONG HISPANICS AND THAT THE FOREMOST NUTRTION-RELATED DISEASE AMONG HISPANICS IS DIABETES MELLITUS OCCURING FROM OVERNUTRITION.

HISPANICS HAVE A HIGH INCIDENCE OF DIABETES, ALTHOUGH THE DISEASE IS ALSO PREVALENT AMONG BLACK AMERICANS, NATIVE AMERICANS, AND PACIFIC/ASIAN ISLANDERS. THE MOST COMMON FORM OF DIABETES AMONG HISPANICS IS NON-INSULIN DEPENDENT DIABETES, WHICH REPRESENTS 95 PERCENT OF ALL REPORTED CASES OF THE DISEASE NATIONWIDE. FOR THAT REASON, WHEN I MENTION THE WORD "DIABETES," I AM SPECIFICALLY REFERRING TO NON-INSULIN DEPENDENT DIABETES.

OF ALL HISPANICS, MEXICAN AMERICANS ARE THE MOST SUSEPTABLE TO DIABETES, WITH A RATE OF INCIDENCE THREE TO FIVE TIMES HIGHER THAN THE GENERAL POPULATION. AMONG THE COMPLICATIONS ARISING FROM DIABETES ARE AMPUTATIONS, BLINDNESS, KIDNEY FAILURE, HEART DISEASE, AND STROKE. BY AVOIDING OBESITY, MOST HISPANICS CAN PREVENT THEIR CONTRACTING THE DISEASE. THIS IN TURN WILL PREVENT THEM FROM SUFFERING THOSE OTHER MORE SEVERE COMPLICATIONS SUCH AS HEART STROKE.

FOR THOSE WHO ALREADY HAVE DIABETES, WE NEED TO ENSURE THAT THEY RECEIVE THE NECESSARY MEDICATION TO CONTROL THEIR DISEASE. UNFORTUNATELY, THE DISEASE TENDS IS OFTEN ASYMPTOMATIC, SO MANY PEOPLE DO NOT KNOW THEY HAVE THE DISEASE UNTIL THEY DEVELOP SEVERE COMPLICATIONS. ONCE THE COMPLICATIONS OCCUR, NO MEDICATION CAN ORDINARILY PREVENT THE ONSET OF BLINDNESS OR THE NEED FOR LIMB AMPUTATION.

AS A NOTED DIABETES RESEARCHER, DR. MICHAEL STERN, WROTE IN A LETTER ADDRESSED TO ME:

"EVEN AMONG DIABETICS WHO HAVE BEEN DIAGNOSED, MEXICAN AMERICANS APPEAR TO BE NOT AS WELL CONTROLLED AS NON-HISPANIC DIABETICS, THAT IS, THEY RUN HIGHER BLOOD SUGARS. WHETHER THIS IS BECAUSE THEY HAVE LESS ACCESS TO MEDICAL CARE, LESS SATISFACTORY CARE OR BECAUSE THEY TEND TO FOLLOW THE PRESCRIBED MEDICAL REGIMEN LESS ADEQUATELY IS NOT KNOWN."

DR. STERN IS AN EXPERT ON DIABETES, WHO CONTRIBUTED A MONOGRAPH ON THE SUBJECT THAT WAS INCLUDED IN THE SECRETARY'S TASK FORCE REPORT ON BLACK AND MINORITY HEALTH. HE CONDUCTS HIS RESEARCH AT THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER IN SAN ANTONIO.

IN RESPONSE TO THE HIGH INCIDENCE OF DIABETES AMONG MINORITIES, I INTRODUCED, IN SEPTEMBER OF LAST YEAR, H.R. 3259, THE "DIABETES PREVENTION ACT OF 1987." THIS BILL IS INTENDED TO REDUCE THE PREVALENCE OF DIABETES AMONG MINORITY POPULATIONS AT SPECIAL RISK. I SUBSEQUENTLY CONVENED A MEETING ON MY BILL HERE IN WASHINGTON. AMONG THE INVITEES WERE THE DIABETES PROGRAM DIRECTOR FOR THE CENTER FOR DISEASE CONTROL, AND REPRESENTATIVES FROM THE AMERICAN DIABETES ASSOCIATION AND THE NATIONAL DIABETES ADVISORY BOARD.

I WOULD LIKE TO CONCLUDE MY REMARKS WITH A FEW RECOMMENDATIONS, WHICH ARE LARGELY BASED ON DR. STERNS SUGGESTIONS ON MY DIABETES INITIATIVE. HIS RECOMMENDATIONS ARE, HOWEVER, GENERALLY APPLICABLE TO THE GENERAL HISPANIC HEALTH DISPARITY WE ARE SO CONCERNED ABOUT.

I WOULD LIKE TO SUGGEST, FIRST, THAT THERE IS A NEED FOR COMMUNITY-BASED, MULTI-MEDIA HEALTH EDUCATION PROGRAMS TARGETING THE HISPANIC POPULATION AND INFORMING THEM ABOUT PROBLEMS SUCH AS: DIABETES, DRUG ABUSE, AND AIDS -- AND WHAT STEPS CAN BE TAKEN TO DEAL WITH THOSE PROBLEMS.

AS DR. STERN HAS ALSO NOTED: "PRIOR EXPERIENCE WITH OTHER PROGRAMS ADDRESSING PRIMARILY HEART DISEASE HAVE MADE USE OF ONE-MINUTE PUBLIC SERVICE ANNOUNCEMENTS ON RADIO AND

TELEVISION." HE NOTES THAT SIMILAR PROGRAMS CAN BE USED ON SPANISH LANGUAGE TELEVISION, WHICH USE 5 TO 10 MINUTE PUBLIC INFORMATION FORMATS.

SUCH ANNOUNCEMENTS SHOULD INCLUDE INTERVIEWS WITH DOCTORS, DIETICIANS, AND OTHER HEALTH CARE PROFESSIONALS. IT WOULD ALSO BE HELPFUL TO HAVE "TESTIMONIALS FROM ROLE MODELS AND COMMUNITY LEADERS, WHO HAVE TAKEN THE RECOMMENDED STEPS TO SAFEGUARD THEIR HEALTH.

HEALTH EDUCATION PROGRAMS SHOULD PRESENT AN OVERIVIEW OF THE MAJOR CHRONIC DISEASES OF HISPANICS. THE INFORMATION SHOULD INCLUDE EXPLANATIONS OF RISK FACTORS AND CHRONIC DISEASES SUCH AS: AIDS, DRUG USE, FAMILY HISTORY, ALCOHOL ABUSE, OBESITY, MALNUTRITION, DIABETES, INFANT MORTALITY, AND UNINTENTIONAL INJURIES.

THOSE SAME PROGRAMS SHOULD BE AIMED AT INFORMING PEOPLE OF WHAT AVAILABLE DIAGNOSTIC SCREENINGS EXIST FOR THOSE RISK FACTORS AND DISEASES AND HOW THEY CAN REQUEST THOSE SCREENING TO BE PERFORMED.

WE ALSO REQUIRE CONTINUING EDUCATION PROGRAMS FOR HEALTH PROFESSIONALS, INCLUDING MAKING PHYSICIANS MORE RESPONSIVE TO THE HIGH INCIDENCE OF CERTAIN DISEASES SUCH AS DIABETES. TOO MANY PHYSICIANS ARE NOT AWARE OF THE HIGH INCIDENCE OF DISEASES LIKE DIABETES, EVEN THOUGH THEY TREAT PREDOMINANTEY HISPANIC PATIENTS.

BUT MOST OF ALL, WE MUST SEEK TO ACQUIRE MORE DATA ON THE HEALTH STATUS OF HISPANICS. I BELIEVE YOU HAVE GREATLY ASSISTED US IN THE TASK BY REQUESTING THE GENERAL ACCOUNTING OFFICE TO SURVEY THE AVAILABLE DATA ON HISPANIC NUTRITION AND HEALTH. I HOPE TO CONTINUE WORKING WITH YOU IN THE FUTURE TO ADDRESS THESE CONCERNS. AGAIN, MR. CHAIRMAN I WISH TO THANK YOU FOR YOUR THOUGHTFUL INVITATION TO TESTIFY BEFORE YOUR COMMITTEE.

Prepared Statement of Hon. Solomon P. Ortiz, a Representative in Congress From the State of Texas

Mr. Chairman, I welcome the opportunity to speak to you today on the serious matter of poverty and hunger among Hispanics. As a representative of an area of the country which suffers an extremely high unemployment rate, I receive numerous inquiries from individuals asking for public assistance.

An essential means of feeding the hungry is through the Temporary Emergency Food Assistance Program (TEFAP). It has recently come to my attention, however, that certain commodities will no longer be available from the TEFAP, particularly cheese. This reduction in cheese to needy families in my district will have a devastating effect. The amount of persons receiving food commodities under the TEFAP program is staggering. I have received numerous letters from individuals in my district pleading that this program be continued. This program is vital because it is a direct and visible means for assisting poor people.

The persons who receive these food items are a diverse group of needy individuals. Some are elderly, single heads of households with little formal education, large families, widows, persons with little formal education, disabled, unemployed or any combination of these descriptions. Many of these individuals would like to see stricter qualifications for those receiving commodities and food stamps.

According to Mr. Wayne Kuykendall, Director of the Food Distribution Program in Texas, 501,620 families participated in the TEFAP in December of 1987. This translates to approximately two million individuals who received commodities under this program for that month in December. It is my understanding that the number has been increasing in 1988.

The reduction of commodities available through the TEFAP program will be noticeably missed. In many cases, these items are a much-needed supplement to social security benefits and food stamps. In some cases, these commodities serve as a substitute for applying for food stamps or as the sole source of public assistance.

Numerous individuals have expressed their concern that other countries receive priority in the distribution of surplus commodities available through the federal government. If this is true, than the priority the United States exhibits must be changed.

It is my opinion that we as a government must have a caring attitude for those less fortunate in our society. We as government leaders must have accurate and complete information from which to adopt a national policy which addresses the concerns and needs of the indigent. In this regard, hunger in the U. S. should be considered a major domestic priority.

HISPANIC POPULATION DEMOGRAPHICS

According to an August 1987 Current Population Reports: Population Characterics, Hispanics comprise 18.8 million of the total population of the United States. This is an increase of 700,000 persons in the Hispanic population since 1986. According to the same report, the Hispanic population has increased by 30 percent (or by 4.3 million civilians) since 1980.

Poverty among the Hispanic population has not improved over the past few years. As indicated by a recent Census Advance Report, the poverty rate for Hispanic families has been fluctuating: in 1981 the poverty rate was 23.5%; the rate rose to 27.2% in 1982 and has steadily declined to its current level of 24.7%. (1)

MARCH 1987

Hispanic Population	Number in U.S.	Percent of Hisp. Pop.(1)
Mexican origin	11.8 million	63.0%
Puerto Rican origin	2.3 million	12.0%
Cuban origin	1.0 million	5.0%
Central and South* American origin	2.1 million	11.0%
Other Hispanic origin	1.6 million	8.0%

	Hispanics		Non Hispanics	
	1987	1982	1987	1982
Population(2) (in thousands)				
Total persons	18,790	15,384	219,999	212,014
% of total pop.	7.9	6.8	92.1	93.1

	Tot. pop.	Mex.	Puerto Rican	Cuban	C&S Amer.	Other Hisp.
Family (median) Income 1986	$29,458	$19,326	$14,584	$26,770	$22,246	$24,240
Family (median) Income 1981	$22,343	$16,994	$11,536	$18,173	$16,875	$19,602

* From here on Central and South American will appear as C & S American.

Sources:

1. U.S. Department of Commerce, Bureau of the Census. Current Population Reports- Population Characterics: The Hispanic Population in the United States: March 1986 and 1987 (Advance Report).

2. Ibid.

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Hispanic Origin Poverty Data(a)

Poverty Rate for Families	1981	1982	1983	1984	1985	1986
Hispanic Origin	23.5	27.2	26.0	25.2	25.5	24.7
Not of Hispanic Origin	10.2	11.4	11.5	10.7	10.4	9.9

Characteristic	Hispanic Tot. pop.	Mex.	Puerto Rican	Cuban	C&S Amer.	Other Hisp.
Below Poverty Level in 1986(3) (in thousands)						
Families	1,085	649	226	39	97	6,149
Percent	24.7	24.9	38.1	13.1	18.7	9.9
Below Poverty Level in 1981 (in thousands)						
Families	875	497	222	37	65	55
Percent	23.5	22.3	41.4	13.7	17.2	17.5

Hispanic Education Attainment(4)

	Total Hispanic	Mex.	Puerto Rican	Cuban	C&S Amer.	Other Hisp.
Median yrs of Schooling, 1987	12.0	10.8	12.1	12.4	12.3	12.7

	Hispanics		Non Hispanics	
	1987	1982	1987	1982
Education Attainment				
4 yrs. or more of High School	50.9	45.4	77.3	72.3

	Hispanics		Non Hispanics	
	1987	1982	1987	1982
4 or more years of college	8.6	7.7	20.6	18.3

(a) According to the Census Department the Poverty determination is based on cash only income.

Sources:

3. U.S. Department of Commerce, Bureau of the Census. Current Population Reports- Population Characterics: The Hispanic Population in the United States: March 1986 and 1987 (Advance Report).

4. Ibid.

Health Characteristics of the Hispanic Population

It is difficult to accurately assess the health status of the Hispanic population because "ethnicity is not uniformly recorded on death certificates in all states. Also, no national mortality figures exist which separate Hispanics from other whites." (5)

According to the United States Department of Health and Human Services, twenty-six percent of the Hispanic population has no medical insurance, this is almost three time the rate for whites (9%).

Hispanic Reproductive Health Characteristics

Characteristic	Total Population	Mex.	Puerto Rican	Cuban	C&S Amer.
Birth Rate(6)	23.9	24.9	19.1	11.1	28.7
% births to Women:					
> 35 years of age	18.3	19.1	23.0	11.4	9.0
< 20 years of age	6.5	6.4	5.5	7.3	9.2
Unmarried	25.6	21.9	49.0	15.9	30.2
% births of low birthweight	6.2	5.7	9.1	5.8	5.6

(5) National Center for Health Statistics: Disease Prevention/Health Promotion. The U.S. Department of Health and Human Services p.219.

(6) Ibid. p.220

United States General Accounting Office

GAO

Briefing Report to Congressional Requesters

March 1988

HEALTH AND NUTRITION

Collection of Vital Statistical Data on Hispanics

GAO/HRD-88-68BR

GAO
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-230485

March 18, 1988

The Honorable Mickey Leland
Chairman, Select Committee on Hunger

The Honorable Albert Bustamante
Chairman, Hispanic Caucus

The Honorable Tony Coelho
Majority Whip

House of Representatives

In your October 28, 1987, letter, you noted that while Hispanics are the second largest minority group in the United States, little is known about their nationwide health and nutrition status and needs or their participation in nutrition programs. Therefore, you requested information regarding the collection of health and nutrition data on Hispanics.

You were particularly interested in national health and nutrition data collected on Hispanics through four surveys: (1) the National Health and Nutrition Examination Survey III, (2) the National Health Interview Survey, (3) the National Medical Expenditures Survey, and (4) the Nationwide Food Consumption Survey. Interest was also expressed in Hispanic birth and death data collected from states under the Vital Statistics Program and data on Hispanic participation in the Department of Agriculture's food assistance programs.

Specifically, you wanted to know:

1. What possibilities exist for including an oversample of Hispanics under the four national health and nutrition surveys conducted by the Department of Health and Human Services and the Department of Agriculture? If a Hispanic oversample is not included, what are the reasons, and are there considerations for its inclusion?

2. Do the Vital Statistics Program's standard birth and death registration forms proposed for 1989 provide for the collection of Hispanic data? If so, what training exists for the use of the Hispanic identifier contained in the forms? How does the Vital Statistics Program operate--can it require states to use a Hispanic identifier?

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3. Do data exist on Hispanic participation in Agriculture's food and nutrition programs? Are Hispanic data unavailable for programs in which racial information is available, and if so, why? What steps would be necessary to obtain Hispanic participation data for these programs if such data are not readily available?

Oversampling involves selecting more respondents from a targeted low-incidence group than are necessary for estimates of the entire sampled group of interest. It is a technique used to permit better estimates of minority groups that would otherwise be selected in too few numbers to allow separate valid analyses of their characteristics. The Health and Nutrition Examination and the Medical Expenditures surveys have arranged to oversample Hispanics in order to arrive at national estimates of the health and nutrition status of Hispanics. The Health Interview and the Food Consumption surveys do not oversample for Hispanics and have no plans to do so at this time, primarily due to the additional cost that would be incurred.

New standard birth and death registration forms have been developed for the Vital Statistics Program, under which birth and death information collected by the states is aggregated. These forms are for voluntary use by states beginning in 1989 and request identification of Hispanics. A Hispanic identifier was not included in the earlier standard forms. Instructions for the use of the Hispanic identifier are provided through Vital Statistics Program materials, such as training booklets and videos.

All 13 of the Department of Agriculture's Food and Nutrition Service food assistance programs collect racial and ethnic data on participants at the local level. Currently, however, national Hispanic participation information is provided in published reports for only four of the programs: (1) Food Stamps; (2) Special Supplemental Food Program for Women, Infants, and Children; (3) Needy Family Program on Indian Reservations and Trust Territories; and (4) Commodity Supplemental Food Program. According to program officials, three more programs have studies underway that will provide nationwide information on Hispanic participation. There was little nationwide information for Hispanic participation in the other six programs. Program officials indicated this was due partly to the lack of centrally compiled data about Hispanic participation in these programs, the added burden on local agencies in compiling existing ethnic data, and the absence of a demand for racial or ethnic data. In addition, because data are generally unavailable on the number of Hispanics eligible for these programs, it is both costly and

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difficult to estimate possible nonparticipation by eligible Hispancics.

As your office requested, the draft report was discussed with cognizant officials of each of the surveys and food programs, and their comments were considered in finalizing the report. Because of the time constraints placed by your office for issuance of the report, it was not possible to provide a draft of this report to either the Department of Health and Human Services or the Department of Agriculture for review and comment.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to the Secretary of Health and Human Services and the Secretary of Agriculture and will make copies available to others upon request.

Should you need additional information on the contents of this document, please call me on 275-5451.

Janet L. Shikles

Janet L. Shikles
Associate Director

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COLLECTION OF DATA ON HISPANICS' HEALTH AND NUTRITION STATUS AND PARTICIPATION IN NUTRITION PROGRAMS

BACKGROUND

Hispanics are the second largest and fastest growing minority group in the United States today. The 1980 Census set the Hispanic portion of the U.S. population at 6.45 percent, or 14.6 million people. According to Census Bureau projections, the Hispanic portion of the population is expected to increase to 9.4 percent, or about 25 million people, by the year 2000.

The three main Hispanic subgroups in the United States are: Mexican Americans (59.8 percent of all Hispanics in the 1980 Census), who are concentrated in California and the Southwest; Puerto Ricans (13.8 percent), who are concentrated in New York and New Jersey; and Cuban Americans (5.5 percent), who are located primarily in Florida. (App. I shows the Hispanic population for each state.) Research has shown that the health status of these Hispanic subgroups varies significantly and that sometimes these groups differ from one another more than they differ from the general population.

Data Collection Systems and Food Assistance Programs

Three of the nationwide health and nutrition data collection systems, the Health and Nutrition Examination Survey III, the Health Interview Survey, and the Medical Expenditures Survey, are operated by the Department of Health and Human Services. The Nationwide Food Consumption Survey is conducted by the Department of Agriculture. The Vital Statistics Program is also operated by the Department of Health and Human Services. These systems are briefly described below. (A summary chart showing each system's mandate, objective, users, estimated cost, projectable populations from its sample, data collection aspects specific to Hispanics, survey period, and data availability is included in app. II.)

National Health and Nutrition Examination Survey III, conducted by the Department of Health and Human Services' National Center for Health Statistics and currently in pretest, will be undertaken as a 6-year study, from 1988-93, to provide critical data on the health and nutritional status of the U.S. population. Two other Health and Nutrition Examination surveys have been completed since 1970. The survey includes extensive medical and nutritional examinations, which allow the discovery of undiagnosed and nonmanifest diseases and an understanding of the nutritional qualities of people's diets. The data will be used to

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estimate the prevalence of various diseases and elucidate the mechanisms of disease development.

In addition to these surveys, from 1982-84 a special survey of Hispanics was done using the Health and Nutrition Examination Survey methodology in the geographic areas of the country where most of the Hispanic population is concentrated. Although this survey was not national in scope, it covered about 76 percent of the 1980 Hispanic population in the United States.

National Health Interview Survey, also directed by the National Center for Health Statistics, is carried out annually and consists of two parts: a general health part that remains relatively unchanged from year to year and a special studies part that focuses on a number of topics of interest (usually to a cosponsoring agency) that vary from year to year. Special topics for fiscal year 1988 include alcohol consumption, AIDS knowledge and attitudes, medical device implants, occupational health, and child health. The survey is designed to address major national health issues and can be used to assess the prevalence, distribution, and effects of illness and disability in the United States and the services rendered for these.

National Medical Expenditures Survey, conducted by the Department of Health and Human Services' National Center for Health Services Research and Health Care Technology, is done every 8-10 years. The current survey was begun in 1986 and will be completed in 1989. Its goal is to obtain and analyze information on health care costs across the nation. Both the previous and current surveys are used to address questions on the kinds and amounts of health care used, their cost, how they are financed, and the implications of changes in health policies on all these.

Nationwide Food Consumption Survey is the seventh in a series of surveys. It is conducted every 10 years by Agriculture's Human Nutrition Information Service to assess the nutritional content of diets for policy-making on food assistance, nutrition education, food production and marketing, and food safety. Data are collected on the general population and on low-income groups, both for individuals and households. The current survey is being conducted over a 12-month period that began in April 1987.

The Vital Statistics Program is administered by the National Center for Health Statistics' Division of Vital Statistics, which

aggregates vital information--such as births, deaths, fetal deaths, marriages, and divorces--collected by the states. Under the program, federal program staff and state officials work together to produce updated standard data collection forms every 10 years. This year a new form has been proposed for adoption in 1989 by interested states.

Agriculture's Food and Nutrition Service Programs offer, in cooperation with state and local governments, food assistance and nutritional education for those in need. These programs were created to improve the nutrition of low-income households, improve nutritional knowledge, reduce food supply surpluses, and help strengthen the agricultural markets for products produced by American farmers. Eligibility requirements for each program vary, but usually include income and family size and sometimes nutritional or health need. (Descriptions of the food assistance programs are provided in app. III.)

OBJECTIVES, SCOPE, and METHODOLOGY

We examined the sampling plans for each of the most recent surveys to determine if they included an oversample of Hispanics that would permit national estimates of their health and nutrition status. We examined the Health and Nutrition Examination Survey for 1988-93, the Health Interview Survey for 1988, the Medical Expenditures Survey for 1986-89, and the Nationwide Food Consumption Survey for 1987-88. If the survey did not include an oversample of Hispanics, we asked survey officials why it did not, what considerations had been given to possible oversampling, and whether future plans for the survey included oversampling.

Regarding the Vital Statistics Program, we reviewed legislation to determine the program's mandates and guidelines for working with the states. We reviewed the proposed 1989 standard registration forms for birth and death, determined what training was planned for the use of the new standard forms, and identified which states currently collect Hispanic data.

We also identified the Food and Nutrition Service programs that collect and report ethnic or racial data on participants and ascertained, through discussions with Service officials, why some programs did not publish ethnic and racial data and what steps would be necessary for these programs to provide data on Hispanics.

Our review was done during December 1987 and January 1988 in accordance with generally accepted government auditing standards.

HISPANIC OVERSAMPLES IN NATIONAL HEALTH AND NUTRITION SURVEYS

Until recently, the sampling plans of the four national surveys included too few members of minority groups to allow separate national estimates of their health or nutritional condition. One solution used to overcome this lack of data, which occurs when attempting to focus on small minority groups, has been to oversample.

The current sampling plans for two of the four national health and nutrition data collection surveys call for oversampling Hispanics in order to arrive at national estimates of their health and nutrition status. These are the larger and more complex surveys, the Health and Nutrition Examination Survey and the Medical Expenditures Survey. The Health and Nutrition Examination Survey plans to sample a sufficient number of Mexican Americans--the largest Hispanic subgroup--to arrive at national estimates for that subgroup. The survey director told us that funding constraints have precluded oversampling the total Hispanic population. The Medical Expenditures Survey will include national estimates of Hispanics in general and, possibly, estimates of the three main Hispanic subgroups: Mexican Americans, Puerto Ricans, and Cuban Americans.

Since 1985, the Health Interview Survey has oversampled blacks in order to increase the precision of related estimates. This survey, however, does not include a Hispanic oversample, and the Nationwide Food Consumption Survey does not oversample any minority group, primarily due to additional cost. (The Health Interview Survey did a partial oversample of Hispanics in its 1987 special topic segment on cancer.) Both surveys collect ethnic data, but do not make nationwide estimates of the Hispanic population in any one year because the survey samples do not include enough Hispanics to allow such estimates.

Although Health Interview Survey officials could not estimate how much a Hispanic oversample would cost, they said it would be a considerable amount, since it would require (1) a change in sampling strategy related to geographic dispersion because Hispanics are geographically concentrated and (2) a large increase in the number of households screened because there are relatively few Hispanics.

The Health Interview Survey director indicated that the entire sampling strategy will be open to review in the next few years and anticipated that oversampling of Hispanics would be a topic of consideration. The sampling strategy is usually reviewed only every 10 years to encourage continuity with the results of previous years. The last change in sampling strategy was implemented in 1985. The director pointed out, however, that the current sampling strategy does not eliminate the possibility

of nationwide estimates other than those made on 1 year's data because it allows for the combination of several years' data on Hispanics to arrive at sufficient numbers for a nationwide estimate. The sampling strategy also provides a capability for follow-ups on respondents of interest in the years after their participation in the survey.

The Nationwide Food Consumption Survey director cited cost as the main barrier for not adding an oversample of Hispanics to the survey. He estimated that screening and interviewing additional households for a Hispanic oversample might add $3 million to the $6 million cost of the survey. Also, the director pointed out that by law the survey was required to include only low-income people, not specific minority groups. The Food Security Act of 1985 mandated that "the Secretary of Agriculture shall, in conducting . . . any nationwide food consumption survey, include a sample that is representative of low-income individuals . . . ." The director believes this coverage of low-income people addresses nutritional problems in minority groups with a high incidence of poverty, even if the particular minorities are not singled out.

Neither the Health Interview nor the Food Consumption survey has any plans for including an oversample of Hispanics, and survey officials pointed out that their primary users have not expressed a need for such an oversample. The primary users of the Health Interview Survey are federal health agencies; for the Food Consumption Survey, Department of Agriculture food and nutrition agencies are the primary users. According to the directors of the two surveys, a Hispanic oversample could be added to the surveys if sufficient interest and funding were available. The four national surveys have review processes that are open to the public for suggestions on inclusion of items. These suggestions are reviewed by program staff and various scientific and agency committees for scientific merit, feasibility, and other factors before final decisions are made.

PROPOSED VITAL STATISTICS STANDARD FORMS INCLUDE HISPANIC IDENTIFIER

The Vital Statistics Program's new standard birth and death registration data collection forms include an item requesting Hispanic identity. These forms also provide for the collection of Hispanic subgroup data on Mexicans, Puerto Ricans, Cubans, and other subgroups.

States are not required to use the standard registration forms. However, federal program officials have worked with the states to explain their need for data requested in the standard forms and have provided various training materials and technical assistance to help in the use of the forms.

In 1987, Vital Statistics Program staff discussed the new forms at the annual meeting of the Association for Vital Records and Health Statistics attended by state registrars, who are responsible for data collection at the state level. Program staff also participated in annual Vital Statistics Cooperative Program workshops held for all participating state officials in three regional locations in 1987.

Additionally, in 1987, program staff distributed booklets to states for use in training funeral home directors, medical staff, and others who will fill out the forms. According to program officials, training videos will be distributed to the states in 1988. Both the booklets and the videos emphasize the importance of collecting data on Hispanics and indicate the usefulness of these data for national planning for their needs. States can also obtain telephone assistance from program staff in completing and processing the forms for data tape production.

States normally collect birth and death information for their own use and then provide a data tape with such information to the Division of Vital Statistics. To offset the cost of producing the data tapes, states are provided federal funds through the Vital Statistics Program. The amount of federal funding states receive is determined by a formula that considers state population and costs relevant to the production of data tapes and staff training. Program funding covers about one-third of the state cost to produce the tapes. In fiscal year 1987, funding ranged from $759,438 in a very populous state to $55,634 in a less populous state. (App. IV shows the funds provided to each state by the Vital Statistics Program and state costs related to data tape production.)

Because the new standard forms were distributed in 1987 and do not need to be adopted until 1989, the states are still deciding whether to use the forms. The chief of the Vital Statistic Program's Registration Methods Branch said that it was too early to arrive at a complete count of the states that will use the forms. Nevertheless, he said that most states have indicated their intention to adopt a form that would be consistent with the standard forms. In 1987, 23 states, the District of Columbia, and New York City had collected Hispanic natality and mortality data for their own needs before a federal need was expressed, and the chief expected an additional 10 states to collect such information in 1989. (The states that collected Hispanic information in 1987 are listed in app. I.)

AVAILABILITY OF DATA ON HISPANIC PARTICIPATION IN DEPARTMENT OF AGRICULTURE FOOD ASSISTANCE PROGRAMS

The Food and Nutrition Service collects racial and ethnic data for its food assistance programs in order to ensure

compliance with the Civil Rights Act of 1964. Such data are usually collected at the local levels and have not always been aggregated on a nationwide basis. According to the director of the Food and Nutrition Service's Civil Rights Office, the data are periodically reviewed to assure that civil rights goals are met.

Of the 13 food assistance programs, 4 have produced national data on Hispanic participation: Food Stamps (12 percent of participants are Hispanic); Special Supplemental Food Program for Women, Infants, and Children (20 percent); Commodity Supplemental Food Program (12 percent); and Needy Family Program on Indian Reservations and Trust Territories (1 percent). According to Food and Nutrition Service officials, three more programs have studies underway on nationwide participation that will aggregate Hispanic data. These could be available during the next year. The other six programs do not have data available and studies are not planned to compile participation data.

Service officials indicated that creation of estimates on the number of potentially eligible people who could participate in the various programs would be costly and time consuming because they would probably require the collection of new data. No data base exists that contains data in the same form as the varying eligibility requirements for the 13 food programs. For example, some programs use health needs as well as income to determine eligibility. While this type of information might be available from several data sources, there are no precise counts available of those who match the various eligibility requirements. These estimates are only as reliable as the assumptions and data bases on which they are based.

Two of the 13 programs have developed estimates of the number of potentially eligible people who could participate in the programs. The Food Stamp program, the largest food assistance program, has used Census Bureau data to arrive at rough estimates of the general eligible population who might participate in the program. But this program has not estimated the number of members of racial or ethnic groups that are potentially eligible.

A study was completed in July 1987 that estimated both general eligibility and racial or ethnic eligibility for the Special Supplemental Food Program for Women, Infants, and Children. The study used several data bases to match the complicated program eligibility requirements and cost $400,000. There are three facets to eligibility in the program: participants must be (1) pregnant, breastfeeding, or postpartum women, or infants and children up to their fifth birthday; (2) of low income, with earnings that do not exceed 185 percent of the federal poverty level (states can set lower limits); and (3) at risk that is either medically or nutritionally based. The study

used all three criteria to estimate the number of people potentially eligible for the program. The study drew on data from several sources: a special analysis of the 1980 Census data, an earlier National Health and Nutrition Examination Survey, the 1980 National Natality/Fetal Mortality Survey, and state-level vital statistics.

A key finding of the study published in its first report was that of the estimated 7.5 million people in the general population potentially eligible to participate in the program, an estimated 40 percent participated in fiscal year 1984. According to Food and Nutrition Service officials, data on the estimated number of potentially eligible Hispanics, along with their participation in the program, will be published in another report soon. The Food and Nutrition Service has no plans for further studies on program participation or potential eligibility.

APPENDIX I

TOTAL STATE POPULATIONS AND PERCENTAGE OF HISPANICS[a]

	Total population	Percentage of Hispanic origin	Hispanics identified on birth and death certificates in 1987[b]
Alabama	3,893,888	0.86	-
Alaska	401,851	2.37	-
Arizona	2,718,215	16.21	Yes
Arkansas	2,286,435	0.78	Yes
California	23,667,902	19.20	Yes
Colorado	2,889,964	11.76	Yes
Connecticut	3,107,576	4.01	-
Delaware	638,333	2.77	-
D.C.	594,338	1.63	Yes
Florida	9,746,324	8.80	Yes[c]
Georgia	5,463,105	1.12	Yes
Hawaii	964,691	7.39	Yes
Idaho	943,935	3.88	-
Illinois	11,426,518	5.56	Yes
Indiana	5,490,224	1.59	Yes
Iowa	2,913,808	0.88	-
Kansas	2,363,679	2.68	Yes
Kentucky	3,660,777	0.75	-
Louisiana	4,205,900	2.36	-
Maine	1,124,660	0.45	Yes
Maryland	4,216,975	1.54	-
Massachusetts	5,737,037	2.46	-
Michigan	9,262,078	1.75	-
Minnesota	4,075,970	0.79	-
Mississippi	2,520,638	0.98	Yes
Missouri	4,916,686	1.05	-
Montana	786,690	1.27	-
Nebraska	1,569,825	1.79	Yes
Nevada	800,493	6.73	Yes
New Hampshire	920,610	0.61	-
New Jersey	7,364,823	6.68	Yes
New Mexico	1,302,894	36.63	Yes
New York	17,558,072	9.45	Yes
North Carolina	5,881,766	0.96	-
North Dakota	652,717	0.60	Yes
Ohio	10,797,630	1.11	Yes
Oklahoma	3,025,290	1.90	-
Oregon	2,633,105	2.50	-
Pennsylvania	11,863,895	1.30	-
Rhode Island	947,154	2.08	-

	Total population	Percentage of Hispanic origin	Hispanics identified on birth and death certificates in 1987[b]
South Carolina	3,121,820	1.07	-
South Dakota	690,768	0.58	-
Tennessee	4,591,120	0.74	Yes
Texas	14,229,191	20.98	Yes
Utah	1,461,037	4.13	Yes
Vermont	511,456	0.65	-
Virginia	5,346,818	1.49	-
Washington	4,132,156	2.90	-
West Virginia	1,949,644	0.65	-
Wisconsin	4,705,767	1.34	-
Wyoming	469,557	5.22	Yes

[a]Data from the 1980 U.S. Census.

[b]Data from the chief, Registration Methods Branch of the Vital Statistics Program run by the National Center for Health Statistics.

[c]Florida collects Hispanic birth data but not death data.

NATIONAL HEALTH AND NUTRITION DATA COLLECTION SYSTEMS

	Legislative authorization[a]	Key objectives	Primary users	Total estimated costs[b]
National Health and Nutrition Examination Survey III	National Health Survey Act of 1956	Provide critical data on the health and nutrition status of the U.S. population	-Public health agencies -Agencies that cosponsor collection of data -Private sector researchers, such as academics	-Estimate unavailable because sample not finalized
Hispanic Health and Nutrition Examination Survey	National Health Survey Act of 1956	Obtain data on health and nutrition of Hispanics	-Public health agencies, especially those covering diseases that may be ethnically related -Private sector researchers, such as academics	$34 million

APPENDIX II

APPENDIX II

Possible population projections	Data collection techniques for Hispanics	Survey or data collection period	Data availability
Entire U.S. population, blacks, Mexican Americans	-Use bilingual interviewers and staff -Use Spanish translation -Use staff specially trained in Hispanic diet for nutrition aspects of the survey	6-year study from 1988-93	-Tapes will be sold, and donated to schools of public health -National Center for Health Statistics publishes results in Vital and Health Statistics Series 11 and in journal articles
For specific geographic areas, all Hispanics, plus subgroups: -Mexican, -Puerto Rican, and -Cuban	-Used bilingual interviewers and medical staff -Used Spanish translation of survey -Used interviewers specially trained in nutrition of Hispanic diet and medical staff trained in rudimentary Spanish	Data collection 1982 to 1984	-Data tapes available through sales and donated to researchers -10 of 18 data tapes are now available -Bibliography available of products to date

	Legislative authorization[a]	Key objectives	Primary users	Total estimated costs[b]
National Health Interview Survey	National Health Survey Act of 1956	Collect data on major national health issues	-Federal health agencies, especially collaborating agencies for topics -Market researchers -Schools of public health	$10.3 million
National Medical Expenditures Survey	General authorities of the Assistant Secretary of Health	Obtain and analyze data on health care costs for U.S.: (1) Households and (2) Institutions	-Congress -Federal public public health agencies -Health professionals -Insurance Cos. -Private sector researchers -Treasury -OMB, OTA, CBO -GAO	$55 million

APPENDIX II

Possible population projections	Data collection techniques for Hispanics	Survey or data collection period	Data availability
Entire U.S., blacks since 1985	-Use experienced Census staff for data collection -Use bilingual household members to translate Spanish for respondents	Data collected continuously during each year since 1957	-Data tapes sold -National Center for for Health Statistics publishes results in various sources, including Vital and Health Statistics Series 10
Entire U.S., blacks, and, in the household component only, Hispanics and possibly subgroups: -Mexican, -Puerto Rican, and -Cuban	-Use bilingual interviewers when requested by respondents	-Began in 1986, all data collection planned to be complete by 1989	-Data tapes available through sales -Many analyses planned, but survey staff open to requests for special analyses

	Legislative authorization[a]	Key objectives	Primary users	Total estimated costs[b]
Vital Statistics Program	Health Services Research and Evaluation and Health Statistics Act of 1974	Provide national statistics on births, deaths, fetal deaths, marriages, and divorces (from state data)	-Federal agencies -Private sector researchers -Social welfare agencies -Private businesses -Actuarial groups	$10 million for 1989
Nationwide Food Consumption survey	Food Agriculture Act of 1977	Nationwide study of food consumption to asses nutritional content of diets for policy-making on food production and marking, food safety and food assistance, and nutrition education	-Related federal agencies -Private sector researchers -Private businesses	$6 million (to add oversample of Hispanics would cost an additional $3 million)

[a]Legislative citations provided by data system staff.

[b]Estimated costs were based on information provided by survey and program directors.

APPENDIX II

Possible population projections	Data collection techniques for Hispanics	Survey or data collection period	Data availability
Entire U.S., and in 1989, Hispanics plus subgroups: -Mexican, -Puerto Rican, and -Cuban	Encourage state cooperation through: -booklets -videos -workshops -state visits -visit to state registrars' annual conference -Technical assistance -Federal funds to buy state data tapes	Data collected from states annually	-Data & tapes available in 1-1/2 years, published reports in 3 years from end of calendar year
Entire U.S., plus: -Low-income	-Use bilingual interviewers in certain areas (such as Texas)	Current survey 4/87 to 3/88	-Data tapes sold -Many analyses funded by NFCS are done extramurally

DEPARTMENT OF AGRICULTURE FOOD AND NUTRITION SERVICE PROGRAMS

The Food and Nutrition Service operates food assistance programs for those in need in cooperation with the states and local governments. Descriptions of the 13 programs follow.

THE FOOD STAMP PROGRAM

Through a cooperative system, federal, state, and local governments issue food stamps in order to supplement the food buying power of low-income households and thereby improve their nutritional status. The program is administered nationally by the Food and Nutrition Service and covers all states. United States citizens and legal aliens are eligible if they meet household income and asset requirements, meet work requirements, and have a social security number. The elderly and disabled are permitted certain eligibility exceptions.

The current Food Stamp program originated in 1964 and expanded nationwide in 1974. Participation peaks in periods of high unemployment, inflation, and recession. In 1987, an average of 19.1 million people participated in the program per month, at a cost of $11.7 billion.

SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN

The Special Supplemental Food Program for Women, Infants, and Children is administered by the Food and Nutrition Service to provide supplemental foods and nutrition education through local agencies to low-income pregnant, postpartum, and breastfeeding women, and infants and children up to 5 years of age. To be eligible, these people must meet income requirements, be determined to be at nutritional risk through a medical examination by health professionals, and reside in an approved grant project area. Supplemental foods, such as infant formula, eggs, cheese, and milk, are distributed directly to participants. If a local agency reaches its maximum participation level, it then fills vacancies with those applicants at greatest nutritional risk.

The Special Supplemental Food Program for Women, Infants, and Children began in 1972 and operated at a cost of $1.7 billion in fiscal year 1987, when average monthly participation was 3.4 million people.

COMMODITY SUPPLEMENTAL FOOD PROGRAM

The Commodity Supplemental Food Program is a state grant program administered by the Food and Nutrition Service to provide supplemental foods to low-income pregnant, postpartum, and breastfeeding women, infants and children up to 6 years of age, and the elderly. In some of the 12 states participating, eligible persons must also be determined to be at nutritional risk. Although the Special Supplemental Program for Women, Infants, and Children and the Commodity Supplemental Food Program may operate in the same area, individuals may not participate in both programs.

The program was established in 1969. The program operated at a cost of $55 million in fiscal year 1987, serving an average of 190,000 people per month.

NEEDY FAMILY PROGRAM ON INDIAN RESERVATIONS AND TRUST TERRITORIES

The Department of Agriculture provides food products to households on Indian reservations and to Native Americans residing in the Trust Territories of the Pacific Islands.

The Department purchased food for this program at a cost of $64 million in fiscal year 1987, and an average of 150,000 people per month participated.

COMMODITIES FOR CHARITABLE INSTITUTIONS

Provides available commodities for meal service to soup kitchens and other charitable institutions. The federal cost in fiscal year 1987 was $158 million.

TEMPORARY EMERGENCY FOOD ASSISTANCE PROGRAM

Surplus commodities are distributed by the Department of Agriculture to the states under the Temporary Emergency Food Assistance Program to help improve the nutritional status of those in need, as well as to help reduce inventories and storage costs. The states receive the surplus food based on the number of people unemployed and the number of people below the poverty level. The states then distribute the food through local institutions, which must require a demonstration of economic need from participants.

The Temporary Emergency Food Assistance Program began in 1981. From 1981 through September 1987, 4.5 billion pounds of commodities have been distributed (cheese, butter, dry milk, honey, flour, corn meal, and rice) with a value of $4.8 billion.

NATIONAL SCHOOL LUNCH PROGRAM

The National School Lunch Program is the largest child nutrition program run by the Food and Nutrition Service. Through it, states receive reimbursement for their public, private (if tuition does not exceed limits), and institutional school lunch programs if these schools meet requirements. The schools must serve lunches that meet Department of Agriculture nutritional standards, provide free and reduced price lunches to the needy (based on income and family size) without discrimination or identification, and operate their food service on a nonprofit basis.

The program subsidizes 24 million lunches each school day in 90,000 participating schools. Federal funding for fiscal year 1987 was $3.7 billion.

SCHOOL BREAKFAST PROGRAM

The School Breakfast Program is also intended to improve the nutrition and dietary practices of children from low-income families through school-sponsored meals. Schools and institutions participating in the program must serve breakfasts that meet Department of Agriculture nutritional standards and must serve children who meet eligibility standards based on income and family size.

The program began in 1966. It served an average 3.6 million children per day in fiscal year 1987 at a total cost of $458 million.

SPECIAL MILK PROGRAM

The Special Milk Program is designed to encourage consumption of milk by school children. Schools, if they do not participate in other Food and Nutrition Service meal service programs, may decide to offer paid milk or free milk, for which children must meet family size and income requirements. The program reimburses the schools for the full cost of the milk distributed without charge, and part of the paid milk costs.

The Special Milk Program was established in 1954, when funds from the Commodity Credit Corporation were permitted to be used to pay for milk. In fiscal year 1987, the federal cost for the milk purchased was $15 million.

CHILD CARE FOOD PROGRAM

The Child Care Food Program provides funds and foods donated by the Department of Agriculture to child care facilities to serve nutritious meals and snacks. Child care providers are eligible if they receive compensation for child care under title XX of the Social Security Act for at least 25 percent of the children in attendance. Also eligible are Head Start programs, settlement houses, and recreation centers. Whether the meals are free to the children or not depends on their family income. Family Day Care Homes are also eligible, but only the children of the provider of the child care need to meet an income criteria. Meals in this case are partially reimbursed.

The Child Care Food Program was authorized in 1978 (after it piloted in 1968 and operated in the interim). Program costs in fiscal year 1987 were $548 million, with an average of 1.2 million children participating each day.

SUMMER FOOD SERVICE PROGRAM

The Summer Food Service Program funds meals and snacks for children in economically depressed areas when school is not in session. Any child up to age 18 may participate, except at residential camps, where participation is restricted to children eligible for free and reduced-price meals.

Until 1975, the Summer Food Service Program was part of the Special Food Service Program for Children. At that time it was established as a separate program. In fiscal year 1987, program costs were $130 million, with 1.6 million children participating per day in the peak summer month.

NUTRITION PROGRAM FOR THE ELDERLY

This nutrition program supplements the Department of Health and Human Services' elderly programs with cash and commodities for meals. Meals are served either in homes or in senior citizen centers or other elderly program settings. In fiscal year 1987, an average of 900,000 people received meals daily at a cost of $139 million.

PUERTO RICO NUTRITION ASSISTANCE PROGRAM

Beginning in July 1982, this program replaced the Food Stamp Program in Puerto Rico with funds provided to Puerto Rico to operate its own food assistance program targeted to needy households. In fiscal year 1987, the federal cost was $853 million, with an average 1.5 million people participating each month.

FEDERAL SHARE OF COSTS TO PRODUCE TAPES ON BIRTH AND DEATH DATA FOR THE VITAL STATISTICS PROGRAM IN FISCAL YEAR 1987

States, territories, and cities	Data tape production costs	
	Federal share of state costs	State costs[a]
Alabama	$136,643	$406,954
Alaska	101,075	300,549
Arizona	113,039	336,137
Arkansas	93,000	276,036
California	759,438	2,275,534
Colorado	176,450	526,147
Connecticut	134,982	401,310
Delaware	56,251	165,780
District of Columbia	69,253	204,403
Florida	323,001	967,106
Georgia	167,978	501,508
Hawaii	87,898	206,008
Idaho	74,497	221,279
Illinois	301,746	901,472
Indiana	127,757	379,455
Iowa	114,706	340,658
Kansas	119,471	355,494
Kentucky	86,617	256,808
Louisiana	102,221	304,201
Maine	95,554	283,262
Maryland	123,248	366,407
Massachusetts	219,074	654,032
Michigan	305,960	914,115
Minnesota	152,711	454,808
Mississippi	105,967	315,255
Missouri	186,106	555,360
Montana	92,419	274,270
Nebraska	111,879	332,416
Nevada	103,442	307,972
New Hampshire	74,895	221,363
New Jersey	167,977	500,871
New Mexico	92,907	276,033
New York	436,487	1,305,978
North Carolina	179,574	536,114
North Dakota	73,706	217,886
Ohio	263,243	786,553
Oklahoma	118,258	352,447
Oregon	119,590	356,788

APPENDIX IV

States, territories, and cities	Data tape production costs: Federal share of state costs	Data tape production costs: State costs[a]
Pennsylvania	311,177	930,608
Rhode Island	91,466	271,279
South Carolina	173,749	518,885
South Dakota	55,634	164,114
Tennessee	150,848	449,599
Texas	395,181	1,184,027
Utah	102,423	304,165
Vermont	89,094	264,054
Virginia	224,628	671,199
Washington	132,505	396,009
West Virginia	77,076	228,356
Wisconsin	192,939	575,199
Wyoming	69,987	206,606
Puerto Rico	60,390	178,463
Virgin Islands	37,837	110,672
New York City	275,754	824,330
Total	$8,609,708	$25,670,334

[a]The National Center for Health Statistics Vital Statistics Program enters into a contract with the states and other registration areas for the production of data tapes providing birth and death data. The program determines funding by the use of a formula that covers about one-third of state costs incurred in the production of the data tapes.

(118225)

PREPARED STATEMENT OF JOHN W. BODE, ASSISTANT SECRETARY, FOOD AND CONSUMER SERVICES, U.S. DEPARTMENT OF AGRICULTURE

Mr. Chairman, and Members of the Committee, thank you for the invitation to appear before you today to discuss the role played by the Food and Nutrition Service (FNS) programs in meeting the food needs of the poor, including those of Hispanic Americans.

Mr. Chairman, as you know, our mission is to ensure that food assistance is available to all needy citizens who cannot provide for themselves. The President's budget recommendation submitted to the Congress several weeks ago is the highest funding request in history for the food assistance programs. The request also adheres to the Bipartisan Budget Agreement, the Budget Summit, if you will, which calls for deficit reductions that exceed the requirements of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987. We plan to live up to our side of this agreement.

On a national scale, the scope of FNS' programs is impressive and varied in nature. FNS administers thirteen food assistance programs primarily for persons with low incomes. Total funding for FNS has increased by $10 billion during the 1980s. Special target groups include nutritionally-needy women, infants, and children, Native Americans, the elderly, and school-age children. The largest of the food assistance programs is the Food Stamp Program.

Food Stamp Program

Started in 1961 as a pilot project in seven States, the Food Stamp Program is expected to expend over $12 billion in Fiscal Year 1988 and to provide assistance during the course of that year to about 18.8 million persons per month. It is our first line of defense against hunger. Any household, regardless of ethnic or racial origin, that meets the following income and asset requirements as well as nonfinancial criteria is eligible for food stamps:

- o Gross Income at or below 130 percent of the poverty level ($14,570 a year for a family of four).
- o Net Income, after deductions, at or below 100 percent of poverty ($11,200 a year for a family of four).
- o Asset Limits, exclusive of home, of $2,000, or $3,000 if the household contains an elderly person.

As you can see, unlike most welfare programs, where eligibility depends on age, disability, or other factors, food stamps are available to many low-income families.

Food stamp benefit amounts are based on household size, income, and assets; benefits received vary accordingly. Our most current data (1985) show that almost 11 percent of all households participating in the Food Stamp Program are Hispanic. Moreover, low-income Hispanics appear to make the same use of the Food Stamp Program as other low-income groups. Although poverty status is not synonymous with food stamp eligibility, in 1985 households of Spanish origin comprised 11 percent of all poor households and were 14 percent of the poor households who reported food stamp receipt.

In order to assist non-English speaking participants, the Food Stamp Program regulations contain bilingual requirements which are designed to assist participants with application and certification materials and to provide program information. For example, the regulations require:

- That the State agency will provide bilingual program information and certification materials in the appropriate language when an appropriate number of non-English speaking households are located in a project area.
- That the State agency will provide both certification materials in the appropriate language(s) and bilingual staff or interpreters for each individual certification office in areas where larger numbers of low-income, non-English speaking households are found.
- That in project areas with a seasonal influx of non-English-speaking households, the State agency will provide bilingual materials and staff or interpreters during the influx in areas where numbers of single language minority low-income households are met or exceeded.

- That the State agency must insure that certification offices provide sufficient bilingual staff or interpreters for the timely processing of non-English-speaking applicants.
- That bilingual notices may contain a telephone number to call for more information.
- That press releases notifying ineligible households that benefits can be restored and advising households to contact the local food stamp office for more information will be translated in bilingual project areas. Upon request, FNS will provide Spanish posters and fliers.
- That any responsible member of a household may designate an authorized representative to act on behalf of the household in applying for benefits, obtaining the food stamps, and using the food stamps.

As a result of these Federal requirements, several States provide the Food Stamp Program application in Spanish (e.g., Texas, New Mexico, Florida, New York, California, Arizona, Nevada, Illinois).

The Food Stamp Program is also available to Spanish-speaking retailers who wish to accept food stamps in their food stores, and many program materials for use by retailers are available in Spanish. (These are the "Official Food List" and "We accept Food Stamps" posters and decals, which are displayed in retail food stores and directed toward recipients, and the "Food Stamp Program Guide for Retailers" and "Tips for Cashiers", which are educational materials for retailers and store employees.)

In certain cases, aliens are eligible to receive food stamps. For example, if a person is a resident of the U.S. and

an alien legally admitted for permanent residence as an immigrant as defined in sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act, he or she may receive food stamps. Aliens, however, represent a small proportion of the total food stamp caseload and recipients.

These program efforts assist Hispanics and other ethnic groups to access the Food Stamp Program more readily and more easily. I would also like to make clear that, the Food Stamp Program is accessible to people who need it. By law, State agencies must process all applications within 30 days of the date they are filed. An application does not have to be completely filled out to be considered filed. In fact, we consider an application filed as long as it contains the applicant's name and address and is signed by a responsible household member or an authorized representative. To meet this standard, State agencies must ensure that eligible households can obtain food stamps by the 30th day after filing. Some households are deemed in need of even faster service and must be given the opportunity to obtain food stamps by the fifth calendar day after an application is filed. Expedited service must be provided to households with less than $150 in monthly gross income and less than $100 in liquid resources, destitute migrant households with less than $100 in liquid resources, homeless households and households

whose combined monthly gross income and liquid resources is less than their rent or mortgage plus utilities. A household does not need a fixed address to receive food stamps.

Child Nutrition Programs

In general, funding for Hispanics in the Child Nutrition Programs has increased steadily since Fiscal Year 1980, from 18.6 percent to 21.3 percent of all funding in these programs. In particular, funding to Hispanics in the National School Lunch Program and the School Breakfast Program has increased from $646 million in FY 1980 to $884 million in FY 1987. It is significant to note that, although Hispanics comprise approximately 8 percent of all children in schools with these two programs, they receive approximately 21 percent of all Federal funding in these programs.

The WIC program (the Special Supplemental Food Program for Women, Infants, and Children) currently serves approximately 3.5 million pregnant and post-partum women, and children up to age five determined by a health professional to be at nutritional risk. In order to be eligible to receive benefits, the household must meet certain income eligibility requirements. In Fiscal Year 1988, we will spend approximately $1.8 billion on WIC, more than twice the 1980 level which reflects a participation increase of over 50 percent since 1981.

In the WIC Program, overall Hispanic participation has grown from 18.9 percent in Fiscal Year 1980 to 20.1 percent in Fiscal Year 1986 of all participation. This constitutes a fairly large percentage of total WIC participation indicating good utilization of the WIC Program by Hispanics.

A related, though smaller program, is the Commodity Supplemental Food Program (CSFP). It serves low-income pregnant, breastfeeding, and post-partum women, infants, children up to the age of 6, and elderly participants. CSFP provides USDA donated commodities which are high in those nutrients usually lacking in the diets of the target populations. In CSFP, overall Hispanic participation has grown substantially, from 8.3 percent of average (both elderly and women, infants, and children) CSFP participation in Fiscal Year 1982 to 11.6 percent in Fiscal Year 1986. Applying the average Hispanic participation figures to total CSFP expenditures reveals that, on average, about $5.5 million were spent on Hispanics in Fiscal Year 1986.

Other USDA programs available to needy persons include the Child Care Food Program, the Summer Food Service Program, the Special Milk Program, and the Nutrition Program for the Elderly. While we have no data on these programs as to the amount of Hispanic participation, the programs are, of course, available to eligible Hispanics.

For all the programs I have discussed, there are many publications printed in Spanish to provide information to Hispanic participants. I have brought with me a display of some of the various publications provided by FNS to Spanish speaking participants so that you can get an idea of their availability.

Summary

In conclusion, Mr. Chairman, the Federal government is doing more now than ever before to meet the food assistance needs of low-income Americans including Hispanics. Moreover, special efforts are being made to assure that Hispanics have full access to food assistance programs.

Mr. Chairman, that concludes my testimony. I will be happy to answer any questions.

ADDITIONAL QUESTIONS FOR JOHN W. BODE

SUBMITTED BY HON. MICKEY LELAND

Congressman Leland: Research conducted by the General Accounting Office indicates three U.S. Department of Agriculture studies in progress which will provide national information on Hispanic participation. Which programs are examined, when were these studies initiated, and when will formal research documents be available.

Mr. Bode: As part of its research agenda, the Food and Nutrition Service routinely conducts a variety of studies to provide detailed information on the programs it administers. The particular studies referenced by the General Accounting Office provide such information for the National School Lunch and School Breakfast Programs, the Summer Food Service Program, and the Child Care Food Program.

We recently released the first of these reports, Characteristics of the National School Lunch and School Breakfast Program Participants. It is based on data collected as part of the National Evaluation of School Nutrition Programs.

The other two studies--of the Summer Food Service Program and the Child Care Food Program--are still in progress. We expect that final reports will be available within the next few months.

Congressman Leland: According to the recent GAO report, USDA program officials cite the lack of centrally compiled data about Hispanic participation, the absence of a demand for racial or ethnic data, and the burden on local agencies for compiling ethnic data as the reasons for the lack of Hispanic participation information. How difficult would it be to expand existing data collection systems to include specific information on Hispanics?

Mr. Bode: Food and Nutrition Service (FNS) reporting requirements are tailored to specific program needs and attempt to be sensitive to the burden on local/State administrators and program participants. In general, our efforts provide good coverage for the largest programs administered by FNS.

Information on Hispanics is collected either regularly or periodically as part of program evaluations for 8 of the 13 food assistance programs administered by FNS. These programs (Food Stamps; National School Lunch; Special Supplemental Food Program for Women, Infants, and Children; School Breakfast Program; Commodity Supplemental Food Program; Needy Family Program on Indian Reservations and Trust Territories; Summer Food Service; and Child Care Food) accounted for over 89 percent of the benefits provided by FNS in Fiscal Year 1987. Such information is not collected for the Nutrition Assistance Program--which is administered as a block grant in the Commonwealth of Puerto Rico--it is assumed to serve exclusively persons of Hispanic origin.

The remaining programs (Special Milk Program, Nutrition Program for the Elderly, Commodity Distribution to Charities, and Temporary Emergency Food Assistance) provide benefits in special settings (food pantries, soup kitchens, congregate feeding sites) that lack mechanisms to routinely count participants, let alone collect information on their detailed characteristics. Expanding data collection on participants to these programs would require significant modification to current operating procedures. Since, in total, these programs account for less than 7 percent of the total benefits spent in programs administered by FNS, it does not seem cost effective to extend data collection on participants to these programs.

Congressman Leland: In your survey to determine characteristics of food stamp households, how do you assure a representative sample of Hispanic participation?

Mr. Bode: Our study of food stamp characteristics relies exclusively on the sample taken for the Food Stamp Quality Control system. Each State selects a random sample of its caseload every year. The Food and Nutrition Service has provided extensive guidance and materials to States and approves each State's sampling plan to ensure that the quality control samples are selected in accordance with sound statistical principles. Our regional offices routinely monitor State implementation of their approved sampling plans. Rigorous application of these principles ensures the representativeness of the sample. As a result, cases with Hispanic members are chosen in proportion to their total number in each State.

Congressman Leland: What plans does the Department have for collecting, analyzing, and reporting information as to the reasons for non-utilization of major food assistance programs among Hispanics?

Mr. Bode: The Food and Nutrition Service continues to monitor participation trends in the major food assistance programs. Our efforts to date have taken a broad view reflecting our interest in participation among all eligibles, not just those of Hispanic origin. We plan to continue those efforts.

It is important to note that there is no evidence that Hispanics are significantly less likely to participate in these programs than other low-income Americans. In fact, quite the opposite is true. For example, the participation rate in the Food Stamp Program among eligible Hispanics (61 percent) is about the same as the overall rate (63 percent).

Congressmen Leland: What steps has the Department initiated to encourage greater food assistance program participation among Hispanics?

Mr. Bode: The Department has taken numerous steps to make our programs accessible to Hispanics (and other minorities). In my testimony, for example, I describe some of the various requirements for bilingual materials, applications, staff, and interpreters contained in Food Stamp Program regulations. If our Civil Rights office determines that there is a language barrier that hinders participation in a local office, we take necessary actions to ensure that the State and local offices eliminate that barrier. We believe this approach is effective since the participation rate among eligible Hispanics (61 percent) is about the same as the participation rate among all eligibles (63 percent).

PREPARED STATEMENT OF MANNING FEINLEIB, M.D., DR.P.H., DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I appreciate the opportunity to appear before you today to discuss the health of Hispanics. I will be presenting some of the data on Hispanics collected by the National Center for Health Statistics (NCHS), discussing the adequacy of such data, and describing several initiatives we have taken to allow us to improve our understanding of the health of the Hispanic community.

NCHS, a part of the Centers for Disease Control, is the Nation's principal health statistics agency, with broad responsibility for monitoring the health of the Nation. In carrying out this responsibility, we make special efforts to focus attention on the health of special population groups, such as Hispanics. In presenting some of our findings on Hispanic health and nutrition, I will be drawing on several of our data systems, including the National Health Interview Survey, the National Health and Nutrition Examination Survey, the Hispanic Health and Nutrition Examination Survey, and the National Vital Statistics System.

Overall, we have found that the health and nutritional status of Hispanics is relatively good. Despite our general impression that Hispanics are not significantly worse off than the general population, there are some differences in health and the use of health care that distinguish Hispanics from non-Hispanics, as well as differences between three primary subgroups of Hispanics: Mexican Americans, the largest subgroup; Puerto

Ricans; and Cuban Americans. I will be referring to the non-Hispanic white and non-Hispanic black populations simply as "whites" and "blacks" to avoid repetition, and I will be summarizing findings rather than presenting detailed statistics.

HEALTH CHARACTERISTICS OF HISPANICS

Maternal and Child Health: Maternal and infant health statistics are among the most sensitive and universally recognized indicators of health status. Approximately 400,000 babies were born to Hispanic mothers in 1985, accounting for about 11 percent of all U.S. births. Fertility rates for Hispanics are considerably higher than for either whites or blacks, making Hispanics the fastest growing ethnic group in the United States even without considering the effects of immigration.

Teenage childbearing is relatively common among Hispanics, and significant proportions of births to Mexican Americans and Puerto Ricans are to unmarried women. Mexican Americans and Puerto Ricans are considerably less likely to obtain early prenatal care than whites, and are very likely to receive late or no care during the pregnancy.

Despite disadvantages in terms of prenatal care, education, teenage status, and marital status, Mexican Americans do not appear to differ significantly from whites in birth outcome.

Low birth weight is about the same as among whites, and infant mortality rates for Mexican Americans are not significantly different from whites. There are no ready explanations for the apparent contradiction between the existence of these maternal risk factors and these relatively positive birth outcomes; hypotheses include maternal nutrition and weight gain, which appears to be favorable among Mexican Americans; and smoking, where we have found that Mexican Americans are far less likely to have smoked during pregnancy than whites.

In 1982-84, NCHS administered direct physical examinations of approximately 5,000 Hispanic children to obtain information on their health, nutrition, and development. Among the findings:

- The prevalence of stunting (low height for age) and wasting (low weight for height) observed for all three Hispanic groups does not differ from that observed for whites and blacks, providing some reassurance that there is no widespread problem of malnutrition in Hispanic children.

- Hispanic children may have inadequate intakes of vitamin A. Our research has shown that differences in vitamin A levels are probably attributable more to poverty and related environmental factors than to ethnicity.

- Mexican American children were found to be more likely to have impaired vision than white children, similar to black children, but differences were not observed between blacks, whites, and Mexican Americans in hearing tests. For both vision and hearing, more impairments were observed among children living in poverty.

- On the average, Mexican American children have more decayed and fewer filled teeth than white children. But, despite the presence of more decay in Mexican American children, 57 percent were cavity-free at age 9, exceeding the goal of 40 percent set forth in the 1990 Health Objectives for the Nation.

- Immunization appears to be nearly universal for Mexican American children aged 4 to 11, despite some concerns that immigration status may work against appropriate immunization.

Morbidity and Health Status: In the aggregate, Hispanics do not appear to differ dramatically from non-Hispanics in level of illness and disability, with Puerto Ricans faring somewhat worse and Cuban Americans somewhat better than whites. When poverty status and age are taken into account, however, Hispanics are less likely to suffer from acute health conditions, less likely to be injured, and less likely to be limited in activity due to a chronic health condition than are whites. Although comparing

favorably to whites in these areas, Hispanics are more likely to assess their health as "fair or poor." However, cultural differences in the perception of health status make it difficult to interpret this finding.

A number of interesting observations can be made about the health risk factors of Hispanics:

- Smoking behavior is different than non-Hispanics: about the same proportion of males smoke as do non-Hispanic males, but they tend to smoke fewer cigarettes. Females smoke less frequently than do non-Hispanic females, and also tend to smoke fewer cigarettes; however, data from the Office on Smoking and Health indicate that the rate of smoking among Hispanic females is increasing rapidly. As noted earlier, Hispanics are far less likely to smoke during pregnancy than non-Hispanics.

- Obesity appears to be a major health problem among Mexican American and Puerto Rican women. Although we found that Hispanic men are similar to non-Hispanics, we found that 30 percent of Cuban American women and 40 percent of Mexican American and Puerto Rican women were overweight, rates similar to those observed in black women.

- Serum cholesterol levels for Hispanics tend to be lower than for whites and blacks. The prevalence of those with high risk serum cholesterol levels is 15 percent among Mexican American, Cuban American, and Puerto Rican men, and ranges from 11 percent among Cuban women to 18 percent among Puerto Rican women.

Use of Medical Care and Preventive Services: The clearest difference between Hispanics and non-Hispanics is in the use of medical care and preventive services. Regardless of age or poverty status, Hispanics are less likely to see a physician or dentist, or be hospitalized, than are whites. Problems relating to hearing, vision, and dental health in children noted earlier occured more frequently in children who had not received medical care recently. Hispanics are also less likely to have received routine preventive care. For example, they are less likely to have breast exams or pap smears, or have their blood pressure checked. Again, we find differences between Hispanic subgroups, with Cuban Americans and Puerto Ricans tending to use health services with greater frequency than Mexican Americans.

These findings present clear challenges for health care providers and educators, and further challenges for us in identifying barriers to care. Some of our survey data indicate that differences in health insurance coverage may partially account for lower use of health services. Mexican Americans are

about three times more likely than whites to have no coverage from either private insurance or Medicaid, and Puerto Ricans are about twice as likely to be uninsured - worse than comparable figures for blacks. Cuban Americans have somewhat better coverage than blacks, but still lag behind whites.

Mortality: The leading causes of death among Hispanics are heart disease, cancer, accidents, stroke, and homicide. Since the Hispanic population is comparatively young, chronic diseases - such as heart disease and cancer - account for an appreciably smaller proportion of deaths than in the non-Hispanic population. We can anticipate that these causes will increase in proportion as we see the Hispanic population age. Even taking into account the younger average age of the Hispanic population, homicide plays a far greater role as a leading cause of death among Hispanics than whites. While this cause ranked 15th for whites, it was the 5th leading cause of death among Hispanics, similar to the ranking for blacks.

Summary: The complexity of factors influencing Hispanic health (income and poverty, culture, nutritional habits, health insurance coverage) make summation of the health of Hispanics difficult. Major differences between subgroups of Hispanics further complicate our work. With data we now have available, we can draw some general conclusions:

- Cuban Americans resemble white non-Hispanics more closely than they resemble other Hispanics in terms of health and use of medical care;

- Evidence for Mexican Americans and Puerto Ricans is more mixed, with many characteristics worse than white non-Hispanics but better than black non-Hispanics. Routine access to medical care and use of preventive health techniques appear to be key problems for these groups, perhaps explained by comparatively low levels of insurance coverage.

ACCOMPLISHMENTS AND ISSUES IN IMPROVING HISPANIC DATA

Today's hearing has provided us an opportunity to review our accomplishments in improving data on Hispanic health over the last several years. I am encouraged that real strides have been made in filling the gaps in our knowledge about the health of Hispanics, and toward institutionalizing the collection of data on Hispanics. Some examples:

- NCHS now includes mortality data on Hispanics in its annual publication Vital Statistics of the United States, and on data tapes that are made available to the public. NCHS has made data on births to Hispanics available in this manner, both in Vital Statistics of the United States and in the annual publication Births of Hispanic Parentage.

- The National Health Interview Survey (NHIS), NCHS' largest population survey, routinely collects a wide range of information on the health status, illness, and disability of Hispanics, as well as their use of health services. This data is available in both published and electronic form. Due to the size of the NHIS sample, analysis of subgroups of Hispanics is possible, as was done in the NCHS report Health Indicators for Hispanic, Black, and White Americans. A recent NCHS report, Health Promotion and Disease Prevention, provides detail on Hispanic health habits and risk factors.

- NCHS has released 10 public use data tapes from the Hispanic Health and Nutrition Examination Survey (HHANES), the first large scale health survey of Hispanics. These data tapes, along with published articles, presentations, and reports, are forming an extensive body of knowledge on Hispanic health and nutrition status, patterns of growth and development, and the need for treatment and care. Data was collected through interviews, physical examinations, and laboratory tests on approximately 12,000 Hispanics, allowing separate analysis of Mexican Americans, Puerto Ricans, and Cuban Americans.

- To promote research based on HHANES data tapes by Hispanic researchers, we have provided funding to the Coalition of Hispanic Social Services and Mental Health Organizations to

support investigator-initiated proposals for analysis of HHANES data. NCHS has also sponsored a series of technical seminars to assist researchers in making use of the HHANES data bases.

We are also making progress on further initiatives to improve data on Hispanics:

- NCHS is working closely with the States toward improved coverage of Hispanics in the Nation's vital statistics system, where basic data on birth and death are obtained. NCHS has recommended that each State include an explicit Hispanic item on vital registration documents as part of a revision scheduled to be implemented by January 1989. We have seen encouraging signs that most States are adopting this recommendation. As reporting becomes more complete, and routine population data become available, major deficiencies in our understanding of Hispanic mortality can be eliminated.

- We are making final preparations for the third National Health and Nutrition Examination Survey (NHANES III), which will update data on Mexican Americans obtained as part of the special study of Hispanics. NHANES III will allow for further investigation of the health and nutrition status of Mexican Americans as well as providing data to monitor changes over time.

- The National Center for Health Services Research and Health Care Technology Assessment is currently conducting the 1987 National Medical Expenditure Survey (NMES). This survey will provide up-to-date national estimates of the use of, and expenditures for, health care services and health insurance coverage, as well as data on sources of payment, employment, income and assets, and demographic information. NMES will cover both the civilian non-institutionalized population and the population using nursing homes and facilities for the mentally retarded, and will provide specific information on certain minorities. Hispanics will be oversampled, and an estimated 4,700 Hispanics will be included in the survey. Data from NMES can be used to examine how Mexican Americans, Puerto Ricans, and Cuban Americans use health services and study the factors tht may be responsible for marked differences in utilization patterns by these groups.

Several problems remain that prevent a more comprehensive picture of the health of Hispanics. First, although their numbers are growing, Hispanics still represent a relatively small percentage of the national population, necessitating costly efforts to oversample Hispanics in population surveys in order to provide adequate data on subgroups of Hispanics. Such oversampling is not always possible. For example, we have recently determined that it will not be possible to produce

separate estimates on the Puerto Rican population as part of NHANES III. The records systems of medical facilities are our primary source of data on use of health care; unlike race, ethnicity is frequently not recorded by medical practitioners, making it difficult or impossible to identify Hispanics through these records. Finally, annual population figures for the Hispanic population by age, race, and sex for each State are not currently available, and are needed to provide estimates of the risk of mortality by cause of death.

Although data on Hispanics are not yet as comprehensive as we would like, we feel that a great deal more is known about Hispanic health than is commonly recognized. The growing number of NCHS publications and data tapes available to researchers reflect encouraging developments. We are proud of the progress we have made, and remain committed to making further improvements in our ability to monitor the health of Hispanics.

I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS.

PREPARED STATEMENT OF FERNANDO S. MENDOZA, M.D., ASSISTANT PROFESSOR OF PEDIATRICS, STANFORD UNIVERSITY SCHOOL OF MEDICINE

The Health and Nutritional Status of Mexican-American Children

Chairman Leland and Committee Members; I would like to thank you for allowing me to testify to your Committee on the health and nutritional status of Mexican-American children. My colleagues and I have been very interested in this subject, and for the last three years have been examining data from the National Health and Nutrition Examination Surveys; the NHANES I and II, and more recently the Hispanic Health and Nutrition Examination Survey (HHANES). Our work has been supported by a grant from the Bureau of Maternal and Child Health and Resource Development. The major goal of our project is to develop a better understanding of the health and nutritional status of Hispanic children and to examine factors which have a major impact on it.

When we first began our work in this area in 1985, there were very few large scale studies published that examined the health and nutritional status of Hispanic children in the United States. Only the Ten State Survey in 1968 had attempted to examine large numbers of Hispanic children, and these were primarily Mexican-Americans in Texas and California, and Mainland Puerto Ricans from New York City. However, this survey examined

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only Hispanics that were identified as Spanish-surname and made assumptions about their ethnic identity based upon geographic region. Those living in Texas and California were classified as Mexican-American and those living in New York City were classified as Puerto Rican. No attempt was made in the survey to have subjects self-identify themselves as to their ethnic group. Therefore, if their name was not on a list identifying Spanish surnames, they were not counted as Hispanic but rather as white. This problem of identification, along with the small sample of Hispanics, the limitation of sampling to primarily the poor, and the sampling of only a few states limited our ability to generalize the survey's finding to the U.S. Hispanic population. Furthermore, in addition to the noted survey problems, the Ten State Survey failed to provide information about the cultural differences among Hispanics, particularly about whether the subjects or their families were acculturated into the U.S. mainstream. This, I believe, is an important factor in understanding health and nutritional behaviors of Hispanics. For Mexican-Americans this was of particular importance since cultural differences existed not only from one geographic area to another but also from one generation to another. Some Mexican-American families had lived in the United States for several generations while others had recently immigrated.

Yet, given the limitations of the Ten State Survey, it confirmed the findings of other smaller studies done on Mexican-American children in the late sixties and early seventies. All of these studies demonstrated that Mexican-American children

showed growth retardation, particularly in height, and also had evidence of nutrient deficiencies, particularly in iron and vitamin A. However, these smaller studies were usually done in sites specifically for the very poor and were of small sample size, therefore again limiting our ability to understand the actual nutritional and health status of the Mexican-American population as a whole. Similar types of problems were present for studies of Puerto Rican and other Hispanic children. The studies addressing health status and health care access were even more sparse, and likewise limited in their scope. In fact, information on death rates for Hispanic children were then, and are still now, relatively nonexistent.

The federal health and nutrition surveys during the sixties and most of the seventies did not specifically identify Hispanics as a separate group from whites. In federal publications from the Health Examination Surveys of the 1960's and the National Health and Nutritional Examination Surveys I and II in the 1970's, mention of white and black differences in health and nutritional status are found, but nothing is said about Hispanics. Although it is possible to identify Hispanics in NHANES I and II, including Hispanic subgroups in NHANES II, the sample sizes available for analysis were very small and, therefore, reliability of the data is a problem.

However, during the latter part of the 1970's federal surveys began to include ethnic self-description for Hispanic subjects, thereby allowing not only for better identification of the Hispanic subject but also the possibility to identify

cultural variability with groups. For example, a Mexican-American could identify him or herself as Mexican-American, Chicano, Mexican, Mexicano, or Hispano. These self-descriptions for Mexican-Americans provide insight into how the individual views him or herself in the process of acculturation into the American mainstream and, as such, are very important in evaluating health and nutritional behaviors. Similar types of assessments are also important for Puerto Rican and Cuban-American subjects.

The first large scale federal health survey to utilize these descriptions was the National Health Interview Survey (NHIS). This national survey provided health status data on Hispanics based on information gathered by home interviews. This resulted in the first federal publication to be directed specifically toward the health status of Hispanics. This publication was entitled "Health Indicators for Hispanic, Black, and White Americans" (Vital & Health Statistics, U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, Series 10, No. 148), and it was the primary work of Trevino and Moss from the National Center for Health Statistics. This study demonstrated not only differences between whites, blacks, and Hispanics in areas of health indicators and health care utilization but also found significant intra-Hispanic differences among Mexican-American, Mainland Puerto Rican and Cuban-American children. This re-emphasized the importance of intra-Hispanic differences. The limitation of this study, however, was that the information from the NHIS was based on the

subject's knowledge of his or her own health status. Therefore, problems of recall and health care access lead to problems of bias. Moreover, the NHIS was not translated into Spanish, but relied instead upon interviewer and family members to translate questionnaire items.

Therefore, because of this persistent lack of information about Hispanics at the beginning of this decade, persons concerned about the health and nutritional status of the U.S. Hispanic population began to work with the National Center for Health Statistics to develop a health and nutrition survey which would overcome the previous methodologic problems. This survey would provide a large sample size, self-descriptors for subjects, a socioeconomically diverse sample, physical and biochemical data which was linked with historical information, and questionnaires which were valid and reliable for the Spanish-speaking subjects and took into account the intra-Hispanic cultural variability of language. This effort produced the Hispanic Health and Nutrition Examination Survey which examined the health and nutritional status of Mexican-Americans in the five southwestern states, Mainland Puerto Ricans in the New york City area, and Cuban-Americans in Dade county. The survey attempted to provide baseline nutritional information and to target specific health care problems to determine their prevalence. In addition to identifying health and nutritional problems, the survey attempted to assess whether appropriate access to health and nutritional programs was occurring in order to meet those needs. The survey

was conducted from 1982 to 1984. Over the past year NCHS has begun to release data tapes to the public for analysis.

Our research group has begun to analyze these data, specifically with regard to the health and nutritional status of Hispanic children. The initial work has focused primarily on the Mexican-American sample from the southwest, and also included an examination of NHANES I and II. However, with continued support from the Bureau of Maternal Child Health and Resource Development, we plan to also examine the health and nutritional status of Mainland Puerto Rican and Cuban-American children. The former group will be compared to Puerto Rican children who live in Puerto Rico. This study will be done in collaboration with the University of Puerto Rico.

Currently, our findings have shown that Mexican-American children identified in NHANES I and II, when compared to white and black children, tend to be stunted in height but have normal weight (Figure 1). However, when socioeconomic status is taken into account (Figure 2), Mexican-American children less than 12 years do not differ in height from white children. For all children, white, black, and Hispanic, socioeconomic status has a significant effect on growth retardation, particularly in stature. Children who lived in poverty were on the average smaller than their same ethnic group who lived above poverty. This finding has also been documented by Jones et al., who found lower mean values of growth for both black and white children who live in poverty (DY Jones et al. "Influences in Child Growth Associated with Poverty in the 1970's: an Examination of HANESI

and HANESII, Cross-sectional US National Surveys," Am J of Clin Nutr 1985;42:714-724). Our findings for the Mexican-American portion of the H-HANES also confirms this. In addition, for Mexican-Americans the greatest degree of stunting seems to occur among children 12-18 years of age. This finding has been present in NHANES I and II, as well as HHANES. This suggests that the Mexican-American adolescent may be particularly at risk for growth retardation. Yet, the data also suggest that for Mexican-American children there has been a secular trend of increased height. When the Mexican-American children from HHANES are compared to children from the Ten State Survey done in 1968, the Mexican-American children in HHANES are two to three centimeters taller (Figure 3). This may imply that either Mexican-American children are having less growth retardation or that our assessment of the growth status of Mexican-Americans is more accurate in HHANES. This improvement in height was also noted by Jones et al., in their assessment of growth pattern of white and black children in the United States, even those in poverty. The presumption is that these improvements in growth among black and white children are a result of health and nutritional programs geared to the poor. This may, likewise, be the case for Mexican-American children.

Added evidence for this improvement is found in the level of iron deficiency among Mexican-American children. Data from the HHANES has shown that less than five percent of Mexican-American children sampled have iron deficiency anemia. This is significantly lower than previously reported rates. However, the

rates for adolescents still remain high. Likewise, preliminary analysis of dietary intakes suggest that children less than five years have the most complete diets among Mexican-American children while Mexican-American adolescents have the worse. We are currently investigating whether this is a result of access to nutritional programs.

In the area of health status, data from the HHANES has shown that Mexican-American children have about the same prevalence of chronic medical conditions as U.S. children in general. This prevalence of chronic medical conditions is not modified by poverty. However, when one examines the perceived health of Mexican-American children as rated by their mother and themselves, a significantly greater proportion believe that they are in poor health than that identified by a physician. This perception of being in poor health among Mexican American mothers and their children was significantly affected by being in poverty and being less acculturated. Those mothers who lived in poverty rated 20 percent of their children in poor health as compared to only 10 percent for those above poverty. Those mothers who only spoke Spanish rated 25 percent of their children in poor health while those who spoke primarily English rated only seven percent in poor health. This same picture was seen among Mexican-American adolescents. In fact, for Mexican-Americans who spoke primarily Spanish, 35 percent of them consider themselves to be in poor health. The above should be compared to the physician's assessment, which rated only one percent of Mexican-American children in poor health.

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Clearly, differences in perceived health exist between the physician and the Mexican-American family. But, in addition, it is also clear that poverty and culture have a major impact on Mexican-American mothers and children, an impact that may not necessarily be assessable by our current medical or nutritional assessments. The state of hunger, for example, may not be reliably measured if we are expecting to assess it only by changes in growth or biochemical parameters. Children may be hungry without changes in their variables. The hungry child, however, may do less well in school or physical activity, measures that are our current surveys do not assess. The greater prevalence of poor health perception among mothers that live in poverty and are less acculturated may result from integration of physical and mental health, the latter being influenced not only by the lack of resources in impoverished environments but also by the emotional stresses of attempting to survive in these environments. For those individuals who also have a different culture from the majority, the process of acculturation, or lack of acculturation, may likewise color the individual's overall sense of well being. For children going through physical, psychological, and social development these factors, particularly that of poverty, would seem to have a very global effect. An effect that may not be fully measured by static measures such as height, weight and biochemical values. It would seem that if we are interested in the effects of poverty on children we will need to assess it in much more dynamic terms. Assessments need to focus on measures of function, measures that will give us an

indication of whether children in poverty have an opportunity to become successful and useful members of our society.

Two clear outcome measures of importance would seem to be developmental attainment or school performance and physical fitness. These measures for Hispanic children will be vital to have, for without them we will be able to go only half way in our understanding of the effects of poverty and culture on children.

I would, therefore, make the following recommendations to the Committee with respect to the need for data to target and increase participation of Hispanics in public assistance programs:

1. It is vital that we ascertain accurate mortality data for Hispanics. This important information continues to be missing, and without it we will not know of what Hispanics are dying of in this country.
2. National surveys need to include Hispanics and be able to identify the three major Hispanic groups: Mexican-Americans, Mainland Puerto Ricans, and Cuban-Americans. This means having adequate sample size for each of these groups to make reliable estimates. In addition, comparative groups, whites and blacks, need to be included in the same survey. The Hispanic groups need to be assessed for their level of acculturation and be provided measures that will be reliable and valid for them. For children, outcomes that measure dynamic processes such as cognitive development and physical fitness need to be assessed in national surveys.

3. National surveys based on residency sampling should be supplemented by studies that can sample individuals and families that are usually missed by such sampling techniques. This would include migrants, the homeless, and adolescents that live outside of established residences. These are groups most likely to lack resources and least likely to be surveyed and use public assistance programs.
4. Lastly, most surveys continue to provide us with only cross-sectional information about Hispanics. We do not know what happens to the subjects over the long-term. For children, this is vital and, therefore, national surveys of Hispanic children need to develop a longitudinal component to allow for assessment of changes. This is of utmost importance if we are concerned whether public assistance programs are effective.

The National Center for Health Statistics is currently developing the NHANES III which will meet many of the data needs noted above. It is important for the well-being of Hispanics in this country that NHANES III continue the work started by the Hispanic HANES.

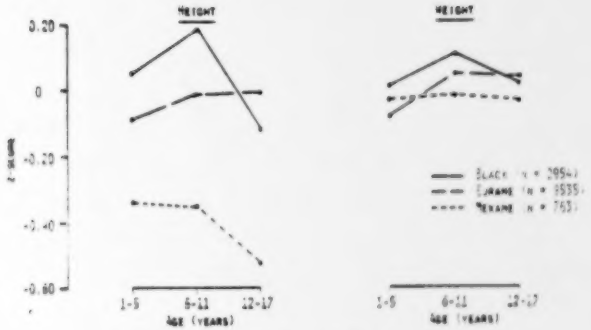

Fig. 1. Height and weight Z scores by age and ethnic group

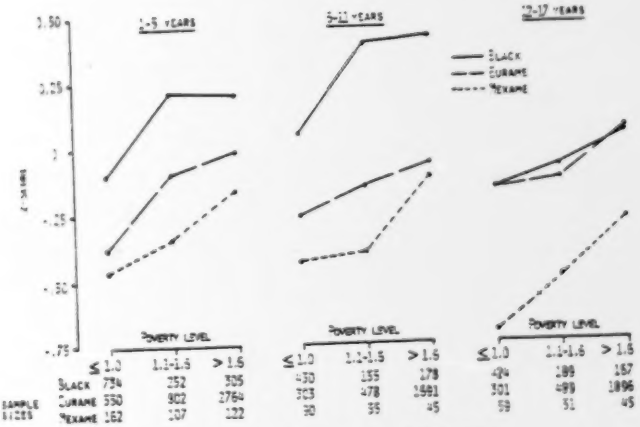

Fig. 2. Height Z scores by age, poverty, and ethnic group.

Source: R. Martorell et al. "Short and Plump Physique of Mexican-American Children," Am J Physical Anthropology 1987, 73:479, 480.

Figure 3

DIFFERENCES IN STATURE RELATIVE TO THE NCHS NORMS FOR SAMPLES FROM HHANES (82-84) AND THE TEN STATE NUTRITION SURVEY (1968-70)

ADDITIONAL QUESTIONS FOR DR. FERNANDO MENDOZA, M.D.

SUBMITTED BY HON. MICKEY LELAND

1. **WHAT ARE THE WEAKNESSES IN THE EXISTING DATA COLLECTION SYSTEM FOR GATHERING INFORMATION ON HISPANICS?**

The major weaknesses in the current system of data collection are: (1) the lack of self-descriptors for Hispanics to allow for subgroup identification (i.e. Mexican-American, Puerto Rican, Cuban-American, etc.); (2) the lack of adequate sample sizes of Hispanic subgroups to make reliable estimates; (3) the inadequate translation of health questionnaires; (4) the limitation of assessing the level of acculturation of the sampled subject; (5) the lack of longitudinal data on Hispanic groups to determine health changes over time; and (5) the absence of mortality data.

FOLLOW-UP: HOW DOES THIS HAMPER YOUR ABILITY TO CONDUCT ADEQUATE AND COMPREHENSIVE RESEARCH ON HISPANICS?

The above problems involving the data collection system have made it difficult even to conduct the most descriptive forms of research. Until the Hispanic Health and Nutritional Examination Survey (HHANES), there had not been any federal survey which had attempted to examine the health of Hispanics. Although the National Health Interview Survey was utilized to describe

reported medical conditions among Hispanics, it was only possible to do so by combining several years of surveys. Even this methodology was inadequate in some cases, resulting in unreliable estimates in certain instances. The HHANES also has had problems of inadequate sample size, particularly for the Cuban-American sample.

Therefore, until recently, the inability of the federal health survey to identify and adequately sample US Hispanics has greatly hindered research on Hispanic health issues. Although some correction of that problem has occurred with the HHANES, the problems of under sampling of Hispanics is still common in most health surveys. Until the problems of adequate identification and sampling are overcome, the other methodological problems will be secondary issues.

2. HOW WOULD YOU PROPOSE THAT NATIONAL DATA COLLECTED INCORPORATES A SYSTEM FOR MEASURING COGNITIVE DEVELOPMENT AND PHYSICAL FITNESS AMONG HISPANICS SURVEYED?

With regard to cognitive development, I would recommend that its assessment be obtained for school age children, 5 years - 18 years. The National Health Examination Survey of the 1960's utilized school test scores to access the child's cognitive development. The National Health and Nutritional Examination Survey III (NHANES III) will have an assessment of cognitive development of school children but this will be assessed by the survey team rather than the individual school. If the NHANES III is successful in obtaining reliable data in this manner then this could be the model for other surveys. If not, then access to

school performance tests should be sought to evaluate the cognitive development of school children. The types of tests selected for this assessment should be reliable and valid for the Hispanic population and sensitive to the group's sociocultural differences.

With regard to physical fitness, measures to determine this have been varied but one frequently utilized is the exercise ergometer. This requires cooperation by the subject and time to perform the examination. Both of these requirements limits its ability in a national survey; however, the need for such information on Hispanics is, I believe, of significant importance to warrant the extra cost it would require. Our research team has demonstrated an increased prevalence of obesity among Mexican-American children as young as ten years. This, with other investigators' findings of increased rates of obesity, cardiovascular disease and diabetes among Hispanic adults, would suggest that obesity, and perhaps poor fitness, may be a major public health issue for the Hispanic community. The assessment of fitness for children ten years and older would provide the research community with the vital data needed to better understand this issue.

3. FROM YOUR WORK WITH LOW-INCOME HISPANIC FAMILIES, HOW CAN WE BETTER TARGET FEDERAL FOOD AND NUTRITIONAL PROGRAMS TO REACH THIS POPULATION TO PREVENT MALNUTRITION?

Currently, we are examining the use of federal food and nutrition programs by Hispanic families through data available in

NHANES. This work is incomplete, but the analysis will determine what proportion of poor Hispanics participate in federal food and nutrition programs and also what proportion of those children with poor nutritional intakes use these services as well. From my own clinical experiences, the best way to target federal food and nutritional programs is to provide excellent outreach. The use of public health nurses or clinic outreach workers seems to be the most effective way to reach those of greatest need (i.e. poor families without phones, transportation, televisions, or other common resources). It will be the children of families with the greatest need who will have the greatest risk for malnutrition. Therefore, our efforts need to be targeted particularly at this group.

Counting numbers and determining percentages with regard to participation in federal food and nutritional program may provide a false sense of security if we are not serving the children with the greatest risk for malnutrition. Among Hispanics this would be that part of the population which is poor, unattached to social services, and perhaps also fearful of governmental intervention. The success of outreach programs come from their ability to connect into the social network of these needed families. The success of this model has not only been demonstrated in this country but other countries as well. I would recommend, therefore, that food and nutritional programs have effective outreach programs.

4

4. BASED ON YOUR RESEARCH AND PRACTICE, WHAT ILLNESSES ASSOCIATED WITH POOR NUTRITION ARE MOST PREVALENT AMONG HISPANICS?

The most common illness associated with under nutrition among Hispanic children would be failure-to-thrive, the problem of poor growth either in weight or stature. Our work with the Mexican-American sample in HHANES seems to indicate that overall this may be less of a problem than it was a decade ago. However, the sampling of HHANES eliminates those children who do not have established residences and, therefore, a group that may be more likely to have this problem. Clinically, my experience is that it is still a common problem among poor Hispanic children, particularly those who are first generation.

Other problems such as iron deficiency anemia and vitamin A deficiency seem to have improved over the past decade as determined by the HHANES.

The other associated issue is that there are diseases which can lead to poor nutrition because of the resultant increase in metabolic demand, loss of calories, or induced anorexia. Childhood diseases such as gastroenteritis, recurrent otitis media, and recurrent upper respiratory infection can place a significant strain on the child's nutritional status. Poor children may not only be at greater risk for these illnesses but may also have less access to health care services to treat them appropriately and, thereby, avoid the resultant nutritional drain. With the increased risk for malnutrition also comes the increased risk for infection, thus creating a downhill cycle.

5

Among Hispanics, and in comparison to other groups in the country, Mexican-Americans are one of the groups with the highest rate of persons without health insurance. Again, being uninsured is most common among the poor and most needy.

5. HOW CAN WE BEST REVISE THE DATA COLLECTION SYSTEM TO ACQUIRE ACCURATE INFORMATION ON HISPANIC SUBGROUPS?

As noted above, the most important issues are self-identification by the sample subject to determine accurately Hispanic subgroup affiliation and adequate sample size to be able to make reliable estimates of prevalences.

One must recognize the heterogeneity of Hispanics, both as Hispanics and as individual Hispanic subgroups. The heterogeneity comes from the diversity of the gene pool. The commonality among Hispanics, that which makes the individual belong to one group or the other, comes from the cultural beliefs, behaviors, and customs. The field surveyor cannot always determine Hispanics just by observation. Only the individual subject has the proper information to correctly classify him or herself.

The other important methodological issue is the reliability and validity of survey measures for Hispanic populations. Whether questionnaires or standardized tests, these must be tested for their reliability and validity among Hispanic populations.

6. HOW CAN WE BEST IMPROVE THE NUTRITION INTAKE AMONG HISPANIC CHILDREN?

This questions first needs to be answered by determining more accurately the nutritional intake of Hispanic children. This will be accomplished by the data from the HHANES. Once this is done then the next step will be to develop recommendations which will not only improve and correct any deficiencies determined but do so in a culturally sensitive way which disrupts cultural food patterns as minimally as possible. This, I believe, will be the most effective way to induce change. In the final analysis, the overall improvement of the nutritional status of Hispanic children will probably come with their improved socioeconomic status.

7. AS A RESEARCHER, HOW WILL PROPOSED BUDGET CUTS FOR DATA COLLECTION AFFECT YOUR WORK?

If budget cuts result in cut backs on data collection on Hispanics, it will have a major impact on research in this area. Although HHANES will be a valuable data set for many investigators, it is really only a preliminary prevalence study which was made to only scratch the surface of this research area. NHANES III will have an adequate sample of Mexican-Americans but may not have an adequate sample of Mainland Puerto Ricans because of budget limitations. Such a limitation on NHANES III would basically eliminate any significant data source on Mainland

Puerto Ricans perhaps until the next century. This would be tragic since among Hispanic subgroups Mainland Puerto Ricans may have the worst health status.

Hispanics have been an overlooked population with respect to almost all federal surveys and studies. To say that one study, the HHANES, is enough to meet the health care needs of this population would be, I believe, a disservice to this group of Americans.

Prepared Statement of Nylda Gemple, San Francisco WIC Director

MY NAME IS NYLDA GEMPLE. I AM THE SAN FRANCISCO WIC PROGRAM DIRECTOR. IT IS INDEED AN HONOR TO HAVE THE OPPORTUNITY OF COMING BEFORE YOU AND SHARING SOME OF MY EXPERIENCES AS A HEALTH PROFESSIONAL AND AS A CONCERNED AMERICAN CITIZEN OF HISPANIC DESCENT. FOR THE LAST TWENTY YEARS I HAVE BEEN EMPLOYED AS A PROFESSIONAL IN THE AREA OF PUBLIC HEALTH, AND FOR THE LAST EIGHT YEARS AS THE DIRECTOR OF THE WIC PROGRAM FOR THE CITY AND COUNTY OF SAN FRANCISCO. BEFORE I DESCRIBE MY CONCERNS ABOUT HISPANIC WOMEN AND THEIR ACCESS TO HEALTH CARE AND PUBLIC ASSISTANCE PROGRAMS, I WOULD LIKE TO BRIEFLY DISCUSS THE DATA THAT WE HAVE COLLECTED IN THE STATE OF CALIFORNIA AND IN THE CITY AND COUNTY OF SAN FRANCISCO. THE TABLE (ATTACHMENT 1) THAT HAS BEEN PROVIDED TO YOU REFLECTS PARTICIPATION IN THE CALIFORNIA WIC PROGRAM AS OF OCTOBER 1987. OUR PARTICIPANTS TOTALLED 280,259. OF THAT TOTAL, 157,362 PARTICIPANTS WERE HISPANICS. THAT AMOUNTS TO 56.1%, OVER HALF OF THE TOTAL PARTICIPATION. AS WE FURTHER BREAK DOWN THE TOTAL INTO THE CATEGORIES OF WOMEN, INFANTS AND CHILDREN, THE HISPANIC PARTICIPATION BECOMES MORE EMPHASIZED.

THE TOTAL FOR WOMEN WAS 94,117, WITH HISPANICS AMOUNTING TO 56,011 OR (54.5%); INFANTS TOTALLED 108,557, WITH HISPANICS ACCOUNTING FOR 65,128 OR (59.9%) AND CHILDREN TOTAL 77,585 WITH HISPANICS AMOUNTING TO 36,223 OR (46.7%).

IN SAN FRANCISCO FOR OCTOBER, 1987, OUR PROGRAM SERVED 8,228

PARTICIPANTS. OF THOSE 3,594 WERE HISPANICS AMOUNTING TO 43.6% OF THE PARTICIPATION. THE TABLE AGAIN REFLECTS THE HISPANIC PARTICIPATION BY CATEGORIES. I WOULD LIKE TO BRING TO THE ATTENTION OF THIS DISTINGUISHED COMMITTEE THAT HISPANICS ARE NOT A MAJORITY OF WIC PARTICIPANTS IN THE CITY AND COUNTY OF SAN FRANCISCO. OTHER CULTURAL/ETHNIC GROUPS, ESPECIALLY SOUTH-EAST ASIANS, AND BLACKS AGGRESSIVELY SEEK ENROLLMENT IN THE WIC PROGRAM AND COMPETE FOR THE SAME SERVICES.

TODAY I WILL BE ADDRESSING THE IMPORTANCE OF PROPER NUTRITION IN PREGNANCY, THE SHORTCOMINGS OF PROGRAMS SUCH AS AFDC AND WHY THE WIC PROGRAM IS NEEDED TO INSURE BOTH NUTRITIONAL ADEQUACY AND HOPEFULLY, PRENATAL CARE FOR CALIFORNIA'S LOW INCOME MOTHERS.

STUDIES HAVE REPEATEDLY SHOWN THAT INADEQUATE DIETS DURING PREGNANCY RESULT IN INCREASED PREGNANCY COMPLICATIONS AND AN INCREASE IN LOW BIRTH WEIGHT INFANTS. CONVERSELY, PROPER DIET CAN AND DOES PLAY A ROLE IN ALLEVIATING PREGNANCY COMPLICATIONS, INCLUDING LOW BIRTH WEIGHT BABIES.

THE NUTRITION NEEDS OF PREGNANT AND LACTATING WOMEN AND INFANTS ARE GREATER THAN ANY OTHER GROUP DUE TO RAPID PHYSIOLOGICAL GROWTH. DIETARY REQUIREMENTS ARE INCREASED FOR ALL NUTRIENTS ABOVE THE NORMAL RECOMMENDED DIETARY REQUIREMENTS (RDA). IT HAS BEEN WELL DOCUMENTED THAT A WOMAN'S NUTRITIONAL HEALTH BEFORE SHE BECOMES PREGNANT HAS A SIGNIFICANT IMPACT ON

HER PREGNANCY OUTCOME. MANY OF THE FACTORS WHICH AFFECT BIRTH WEIGHT ARE NUTRITION RELATED. THESE INCLUDE HER WEIGHT BEFORE BECOMING PREGNANT, WHICH TELLS US IF SHE WAS GETTING ADEQUATE CALORIES, HOW MANY TIMES SHE'S BEEN PREGNANT, WHICH MAY DETERMINE HER NUTRIENT STORES, AS WELL AS WHETHER SHE HAS COMPLICATING MEDICAL CONDITIONS SUCH AS DIABETES, HIGH BLOOD PRESSURE OR SIMPLY DEPLETED NUTRIENT RESERVES DUE TO A LIFELONG LACK OF ADEQUATE FOOD.

LOW BIRTH WEIGHT BABIES ACCOUNT FOR OVER 70% OF THE INFANT MORTALITY CASUALTIES. THOSE WHO SURVIVE OFTEN DO SO UNDER VERY IMPAIRED CIRCUMSTANCES, ROBBED BEFORE BIRTH OF EQUALITY OF OPPORTUNITY.

THINK ABOUT HOW FEW LOW-INCOME WOMEN CONSUME A HIGH QUALITY DIET BEFORE PREGNANCY AND YOU CAN BEGIN TO IMAGINE THE KINDS OF PROBLEMS WE IN THE WIC PROGRAM ENCOUNTER.

THE SUPPLEMENTAL FOOD PROGRAM FOR PREGNANT AND LACTATING WOMEN, INFANTS AND CHILDREN (WIC), A USDA PROGRAM WHICH GIVES NUTRITION EDUCATION AND VOUCHERS TO BE USED IN THE PURCHASE OF MILK, CHEESE, EGGS, ORANGE JUICE, CEREAL, BEANS AND PEANUT BUTTER, OFTEN HAS A 3-8 WEEK DELAY BEFORE GIVING BENEFITS, IF THE SITES ARE UP TO CASELOAD. THESE FOODS CONTAIN THE NUTRIENTS MOST OFTEN LACKING IN THE DIETS OF THESE WOMEN AND CHILDREN; CALORIES, IRON, VITAMIN C, VITAMIN A AND PROTEIN. SEVERAL EVALUATIONS OF THE WIC PROGRAM HAVE SHOWN THAT WOMEN WHO RECEIVE WIC WHILE

PREGNANT HAVE HIGHER BIRTH WEIGHT INFANTS. BECAUSE WIC REQUIRES A PHYSICAL EXAMINATION TO DETERMINE IF THE CLIENT IS ANEMIC, UNDERWEIGHT, OVERWEIGHT, OR OTHERWISE AT-RISK, CLIENTS WHO MIGHT NOT OTHERWISE RECEIVE HEALTH CARE ARE PLACED IN A POSITION WHERE PROBLEMS CAN BE IDENTIFIED AND PROPER INTERVENTION APPLIED. THIS LEADS TO HIGHER THAN USUAL ENROLLMENT IN PRENATAL CARE; THEREBY ELIMINATING ONE OF THE GREATEST RISK FACTORS IN THE SEQUENCE LEADING TO HIGH INFANT MORTALITY. THE LONGER THE PARTICIPATION IN THE WIC PROGRAM, THE BETTER THE OUTCOME. UNFORTUNATELY UNDER THE CURRENT WIC FUNDING, ONLY 23% OF THE ELIGIBLE WOMEN, INFANTS AND CHILDREN ARE ENROLLED DUE TO CASELOAD LIMITS.

WIC BENEFITS ARE ALSO ASSOCIATED WITH GREATER LIKELIHOOD OF CHILDREN HAVING A REGULAR PROVIDER OF MEDICAL CARE AND BEING PROPERLY VACCINATED. THEY ARE ALSO ASSOCIATED WITH SOME EVIDENCE OF BETTER COGNITIVE PERFORMANCE IN CHILDREN. BUT THE BITTER IRONY IS THAT CURRENT ENROLLMENTS PRIORITIES FOCUS ON PRENATAL CLIENTS, KEEPING CHILDREN WHO WOULD OTHERWISE BE ELIGIBLE FROM BEING ENROLLED. THE LONG-TERM CONSEQUENCES OF DENYING PROPER FOOD TO VARIOUS GENERATIONS OF AMERICANS IS YET TO BE SEEN. THE SHORT-TERM CONSEQUENCES ARE WHAT WE DEAL WITH DAILY. THAT IS ANEMIA, SHORTENED ATTENTION SPANS, FATIGUE AND LACK OF INTEREST IN LEARNING. IT IS IMPOSSIBLE TO LEARN ON AN EMPTY STOMACH. UNDER THESE CIRCUMSTANCES, EQUAL OPPORTUNITY IS A CRUEL JOKE, RATHER THAN A REALITY FOR ALL TOO MANY.

IN SAN FRANCISCO WE HAVE ONLY SCRATCHED THE SURFACE OF

ADDRESSING THE REAL NEEDS OF A COMMUNITY INHABITED BY RECENT IMMIGRANTS FROM WAR-TORN CENTRAL AMERICA OR THE REFUGEE CAMPS OF SOUTHEAST ASIA. FAMILIES WITH YEARS OF INADEQUATE DIETS IMPOSED BY THE STRESSFUL REALITY OF SURVIVAL ENCOUNTER NEW PROBLEMS IN THIS COUNTRY, LANGUAGE IS MOST OBVIOUS, BUT BY NO MEANS THE ONLY BARRIER TO GETTING AHEAD. AMONG OTHER FACTORS INTERFERING WITH THE ACCESSING OF HEALTH AND PUBLIC ASSISTANCE ARE THOSE ENCOUNTERED BY HISPANIC FAMILIES IN THE AREAS OF SEVERE PSYCHO-SOCIOECONOMIC CONDITIONS. IT CAN BE SAID THAT HISPANIC FAMILIES RANK AS THE POOREST AMONG THE POOR SINCE MANY OF THEM ARE NOT RESIDENTS OF THE UNITED STATES AND CONSEQUENTLY ARE BARRED FROM RECEIVING PUBLIC ASSISTANCE BENEFITS. BY NATURE THEY ARE NOT AGGRESSIVE SEEKERS; AND THAT COMPOUNDS THEIR LONELINESS AND ISOLATION.

MANY OF OUR HISPANIC MOMS' ARE SINGLE PARENTS AND WITHOUT FRIENDS. THEIR EXTENDED FAMILY CONCEPT (SO REVERED BY OUR CULTURE) HAS BEEN CUT-OFF. SINCE A SOCIAL SUPPORT NETWORK IS NON-EXISTENT AMONG THEM, THEY HAVE BECOME AMONG THE MOST VULNERABLE ETHNIC GROUP OF OUR SOCIETY.

AS EFFICIENT AND COST-EFFECTIVE AS THE WIC PROGRAM HAS PROVEN TO BE, (OF EVERY DOLLAR SPENT ON WIC 3 DOLLARS ARE SAVED ON HEALTH CARE), WIC IS NOT THE ANSWER TO ALL OUR HEALTH AND HUNGER PROBLEMS, FOR THE PROGRAM ONLY SERVICES 1/3 OF ITS ELIGIBLES, FOCUSING ON PRIORITIZING PREGNANT WOMEN ENROLLMENTS FIRST. THE PRIORITIZING METHODS HAVE THE EFFECT OF PRECLUDING

CHILDREN ACCESS TO THE PROGRAM AS OPPOSED TO WOMEN AND INFANTS. A MOTHER DOES NOT GO HOME AND EAT BY HERSELF; WHAT WE HEAR AND KNOW IS THAT SHE WILL SHARE HER WIC FOODS WITH THE REST OF THE FAMILY. WHICH BRINGS ME TO ANOTHER ISSUE; THE NEED FOR SUPPORT IN CONGRESS FOR BREAKFAST AND SCHOOL LUNCH PROGRAMS. IT IS MY HOPE THAT OTHERS GIVING TESTIMONY TODAY WILL ADDRESS THOSE ISSUES.

IN CONCLUSION, MY GOAL AS A WIC DIRECTOR IS TO PROVIDE ACCESS TO THE PROGRAM FOR THE FULL SPECTRUM OF QUALIFIABLE PARTICIPANTS AND THEREBY BRING THOSE PARTICIPANTS INTO THE HEALTH CARE SYSTEM.

CALIFORNIA WIC PARTICIPATION AS OF 10/87

Total	W	I	C
280,259	94,117	108,557	77,585
Hispanics 157,362 (56.1%)	56,011 (59.5%)	65,128 (59.9%)	36,223 (46.7%)

SAN FRANCISCO WIC PARTICIPATION AS OF 10/87

Total	W	I	C
8,228	2745	2846	8228
Hispanics 3594 (43.6%)	1169 (42.6%)	1444 (50.7%)	3594 (43.6%)

ADDITIONAL QUESTIONS FOR NYLDA GEMPLE

SUBMITTED BY HON. MICKEY LELAND

1. WHAT CHANGES DO YOU FEEL ARE NEEDED IN THE WIC PROGRAM TO INCREASE PARTICIPATION AMONG UNSERVED MEMBERS OF THE HISPANIC COMMUNITY?

Increase WIC caseloads nationally to serve 65% of eligibles.

2. HOW STRONGLY DOES THE LANGUAGE BARRIER CONTRIBUTE TO THE LACK OF PARTICIPATION IN THE PROGRAM BY HISPANIC HOUSEHOLDS?

FOLLOW-UP: WHAT STEPS HAVE BEEN TAKEN IN YOUR PROGRAM TO ALLEVIATE THE LANGUAGE BARRIER?

It is the most prevailing factor. In our program every clinic employs bicultural/bilingual workers. Materials and pamphlets are developed in Spanish (colloquial) and their contents discussed with the participants before leaving the clinics. When necessary referral medical appointments are made for the clients to alleviate the anxiety created by non-spanish speaking medical clinic staff.

3. THE COMMITTEE HAS RECEIVED TESTIMONY THAT THE WIC FOOD PACKAGE COULD BE USED MORE EFFECTIVELY IF THE ITEMS ARE NOT ALIEN TO THE NORMAL DIETS OF PARTICIPANTS. WHAT CHANGES WOULD YOU RECOMMEND IN THE PACKAGE TO ASSURE FULL USE OF EACH FOOD BY HISPANIC PARTICIPANTS?

In serving the hispanic population the WIC package needs minimal changes or additions. The population must affected are the Asians.

4. WHAT ARE THE MAJOR HEALTH INDICATORS OF MALNUTRITION PREVALENT AMONG HISPANIC WOMEN AND CHILDREN COMING INTO YOUR PROGRAM?

Anemia, low birth weight, gestational diabetes, and poor dental health.

5. HOW HAS THE PRIORITY SYSTEM AFFECTED THE PARTICIPATION OF CHILDREN IN YOUR PROGRAM?

FOLLOW-UP: WHAT SUGGESTIONS WOULD YOU OFFER FOR ASSURING THE AVAILABILITY OF SERVICES TO LOW-PRIORITY CHILDREN, PARTICULARLY THOSE BETWEEN THE AGES OF THREE AND FIVE YEARS OLD?

The children affected are those between the ages of 2 and 5. Again the only feasible way to serve more children is by Congress appropriating more monies and by U.S.D.A. relaxing or changing the WIC priority system.

PREPARED STATEMENT OF ADOLF FALCON, POLICY DIRECTOR, NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS (COSSMHO)

HISPANIC HEALTH DATA COLLECTION NEEDS

Congressman Leland and members of the Select Committee on Hunger, it is a pleasure to have this opportunity to discuss the very vital health data needs of the Hispanic community and their special impact on the understanding of hunger in Hispanic America.

Health professionals involved with the Hispanic community can tell you that the poverty, lack of access to services, and lack of appropriate preventive care has had a devastating effect in the Hispanic community. Given that almost one in four Hispanic families live in poverty and the serious health status of the Hispanic community, it may seem inappropriate to place such an emphasis on the collection and analysis of Hispanic health data. Certainly there must be more immediate problems deserving of attention. The problems which do exist, however, are not captured through current national health data collection systems. Without basic mortality and health status data the Hispanic community and their health problems are invisible.

THE NEED FOR HISPANIC HEALTH DATA

Solid data, collected along a continuous time period and with reference to other population segments is essential for any analysis of the health needs of the Hispanic community. If the

data are not collected, then for all practical purposes, neither do the necessary programs and services exist. Data drive the needs statements which urges legislators to act. Without data to support the need for programs, Hispanics are left with inefficient and insufficient health care system.

To often it is assumed that Hispanics share the characteristics of other population groups in regard to health, or that data on the "general population" accurately describe Hispanic America. The white community and black community are used as surrogates for the Hispanic experience which results in misconceptions that only reinforce stereotypes.

Those data which are available are the result of special studies. From this limited data we know that there are significant differences between Hispanics and non-Hispanic whites in some health status indicators. For example:

- Diabetes is three to five times more prevalent among Hispanics in South Texas than among non-Hispanic whites in that area.
- Cirrhosis of the liver figures more prominently for Hispanics than for non-Hispanic whites in tables of the ten leading causes of death for the states of California and Texas.
- A special aggregated study of Health Interview Survey data revealed that there are significant differentials in health

services utilization.

- o Use of dental services by Hispanics is much less frequent than use by non-Hispanic whites, particularly children.
- o Preliminary analysis of the Hispanic Health and Nutrition Examination Survey reveal that smoking is rising dramatically among Hispanics, particularly women.

Data also suggest marked differences among the various groups that make up Hispanic America - Puerto Ricans, Cuban Americans, Mexican Americans, Central and South Americans, and other persons of Spanish origin. Some of the more pronounced differentials are in the areas of birth weight, utilization of medical services, and availability of insurance (including Medicaid).

NATIONAL HEALTH DATA COLLECTION SYSTEMS

None of the major health data collection systems currently provide for the sampling of a large enough Hispanic population to provide national data on Hispanic health and nutrition. Two of those systems are the:

- o National Health Interview Survey (NHIS), and the
- o National Health and Nutrition Examination Survey (NHANES).

Oversampling under these surveys would provide valuable health status information on the Hispanic community comparable to that collected for other segments of the population.

In the case of the collection of death and birth certificates, Hispanic identifiers are being used for the first time on the recently released model birth and death certificates. Preparations, however, have not been made to insure proper use of either the identifiers or reporting of the collected data.

In addition to Hispanic health and nutrition status data, there is no ongoing system for the collection of data on Hispanic participation in or access to the various food and nutrition programs which have such a significant impact on the nutritional status of Hispanic America. The currently collected data focuses on WIC and the Food Stamp program and is collected only one month of each year to monitor increasing or decreasing utilization.

National Health Interview Survey

The Health Interview Survey is the principal source of information on the health of the civilian noninstitutional population of the United States. The survey began in 1957 and has functioned as a continuous survey of approximately 112,000 people per year across the country. The survey measures both chronic and acute conditions, disability days and impairments, ~~and a number of health services utilization~~ measures.

For more than 25 years the Survey has produced data which has

served as the cornerstone of our nation's health planning. The HIS produces valuable data by age, sex, and white and black populations, but not for the Hispanic community.

National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES) is designed to collect data that can best or only be obtained from direct physical examination, clinical and laboratory tests, and other related measurement procedures. The NHANES is a prime national source for disease prevalence and health condition data.

The first picture of the health and nutritional status of Hispanic Americans will be available as analyses of the Hispanic Health and Nutrition Examination Survey (HHANES) are published. This one time study involved data collection from 1982-1984 of Mexican Americans in the Southwest, Puerto Ricans in New York, and Cubans in Dade County, Florida. Consequently, no national estimates for Hispanics can be drawn based on HHANES findings. Only regional estimates for the three subpopulations included are possible.

Vital Statistics Records

The use of Hispanic identifiers on the national model birth and death certificates only began in 1988. States may choose,

however, whether or not to adopt the new model. Moreover, the ability to obtain statistically relevant information about Hispanic mortality and natality will depend on the appropriate use of such identifiers. Not until 1990 will we have any national Hispanic data resulting from the inclusion of Hispanic identifiers on the model birth and death certificates.

ANALYSIS

Health Information Survey: One of the most valuable products to come from a national survey has been a report by Fernando Trevino and Abigail Moss for the National Center for Health Statistics, Health Indicators for Hispanic , Black, and White Americans. The report aggregated data from the interview part of the Health Interview Survey for 1978 through 1980 to get a large enough sample for Hispanic specific data. One of the most important findings of this report was that one-third of all Mexican Americans in the United States do not see a physician in the course of a year.

Obviously, one of the severe limitations of this report is that it was a one shot effort and does not provide information along a time line so that health planners would know if the health status of Hispanic Americans was improving or worsening. The need for the collection of data on an ongoing basis was dramatically provided by the Robert Wood Johnson Foundation Survey of Access to Health Care for the American People. The

survey reported that the number of uninsured Hispanics rose almost 50 percent in its 1986 survey compared to the figure reported in the 1982 survey.

Health United States: This report is the basic document for health planners and is probably the most widely used compilation of health data. The Health United States 1986 provides absolutely no information on Hispanics. The National Center for Health Statistics (NCHS) is responsible for aggregating the data, which come from a variety of sources (see Attachment 1). Although some data are obtained from surveys conducted by NCHS, much is also obtained from other agencies. This further illustrates that the lack of data collection or unclear Hispanic data is widespread across agencies.

Report to the President and Congress on the Status of Health Personnel: This report is the basic document for those involved with the problem of health professional distribution and projections of community health professional needs. The lack of appropriate health personnel is one of the most serious problems of the Hispanic community, yet in the fifth report only cursory mention of Hispanics was made. The only information included was the number of Hispanic applications and enrollments in medical school and schools of osteopathy and dentistry. For a several hundred page document with over 140 tables, to only have 3 Hispanic specific numbers is clearly inappropriate.

Deaths of Hispanic Origin: This report which is scheduled to come out later this year is slated to provide information on Hispanic mortality for 15 states from 1979-1981. The report, however, has been delayed approximately two years and demonstrates the problems with Hispanic mortality data as it currently exists. Many states do not use a Hispanic identifier and others use such variances that their data is not usable. For instance, the subpopulations used by New Mexico include a category "Southwesterner" which is clearly unusable.

Hispanic Health Research Consortium: The Consortium is a unique venture between the National Center for Health Statistics and the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO). The Hispanic Health Research Consortium (HHRC) promotes analyses of data from the landmark Hispanic Health and Nutrition Examination Survey. In addition to providing research support funds, the Consortium sponsors quarterly meetings for fellows and other researchers working in the Hispanic health field. Currently-funded research teams are located at Boston University School of Medicine, McGill University, USC Cancer Center, University of Texas Medical Branch at Galveston, University of California at Berkeley, Western Consortium for Health Professions, Indiana University, and the Hispanic Health Council. The Consortium is producing ~~valuable research in what has proven to be a very cost effective~~ manner. The initial findings of Consortium research will be published in a special monograph in late 1988 or early 1989.

DATA NEEDS

Oversampling: The most immediate need in terms of Hispanic health data collection is the oversampling for the Hispanic community in the national health data collection systems, especially the National Health Interview Survey (HIS) and the National Health and Nutrition Examination Survey (HANES). These collection systems are the cornerstone of national health data and the oversampling of Hispanics would provide health planners with vital information they have previously lacked. Oversampling would also provide the ability to compare Hispanic health status to that of other populations and when continued over time would provide the opportunity to track improving or worsening health status in the Hispanic community.

It is vital that oversampling provide information for Hispanic subpopulations as well as the Hispanic community in general. From the data currently available, it is evident that there are wide variations in the Hispanic community's health status by subpopulation group.

A special effort needs to be made to oversample for Hispanics in the 1989 HIS supplement which will be on diabetes. Despite the fact that diabetes is one of the Hispanic community's most serious health problems, we still do not have any solid national data.

Vital Statistics: Uniform mortality data, reflecting standardized data collection procedures in the states, is one of the most basic needs. In order to ensure that the Hispanic identifiers being included on the national birth and death certificates are utilized appropriately it will be important for the National Center for Health Statistics to hold technical assistance sessions for funeral home directors and others who will be using the identifiers. It will also be important to encourage the utilization of the national birth and death certificates in as many states as possible.

Nutrition: In the area of nutrition, it is important that a study be launched of the nutrition components of the Hispanic Health and Nutrition Examination Survey. Furthermore, a study of Hispanic utilization of the full range of food and nutrition programs is necessary to understand the status of nutrition and hunger in Hispanic America. Such a study should not only present utilization rates, but also examine the reasons for any underutilization of various programs.

Analysis: While it is important to collect Hispanic health data, it is equally important to ensure that such data are appropriately analyzed and distributed so that such information ~~is used by health professionals nationally. Funds must~~ be available to undertake research, whether the source be from the public or private sectors. At a minimum, Hispanic specific data

should be included in the national health reports, especially Health United States and the Report to the President and Congress on the Status of Health Personnel in the United States. Furthermore, Hispanic health organizations should be included in the process of analysis. The Hispanic Health Research Consortium has shown this to be a fruitful joining of government and non-profit organizations.

Finally, the National Center for Health Statistics (NCHS) needs to be given more freedom in planning and money for analysis of collected information. The NCHS should be included as a line item in our national budget. Currently 30 percent of the NCHS budget comes from the "1% tap." This tap is a fund paid into by all Health and Human Services agencies of one percent of their budgets. The variability of this fund makes planning by NCHS difficult. For instance, NHANES III was scheduled to sample for 60,000 people, but due to a lack of funds NCHS has had to cut the sample back to 40,000 people. This will make oversampling for the Hispanic community very difficult.

Priority Setting: Guiding the development of these and other priorities should be a comprehensive Hispanic health research and data collection agenda, developed by leading Hispanics and non-Hispanic experts and reflecting the best thinking and ~~understanding of current problems and anticipated needs~~. This agenda would become a powerful tool to use with the nation's leading research institutions, as well as the federal, state,

and local agencies responsible for health data collection, maintenance, and analysis.

The need for health data is of primary concern to the Hispanic community. Without such data it is impossible to plan responsibly for the health needs of the Hispanic community. Appropriate data, however, would allow government, health professionals, the private sector, and others to respond to the health needs of a growing Hispanic community. This current lack Hispanic America can no longer afford. We do not know how many Hispanic men, women, and children die in this country every year. How much longer can we go without even the most basic public health information?

ATTACHMENTS

SOURCES OF DATA

National Center for Health Statistics (DHHS/PHS/OASH)

National Vital Statistics System
National Survey of Family Growth
National Health Interview Survey
National Health and Nutrition Examination Survey
National Master Facility Inventory
National Hospital Discharge Survey
National Nursing Home Survey
National Ambulatory Medical Care Survey

Health Resources and Services Administration (DHHS/PHS)

Physicians Supply Projections (Bureau of Health Professions)

Centers for Disease Control (DHHS/PHS)

National Morbidity Reporting System (Epidemiology Program Office)
Abortion Surveillance (Center for Health Promotion and Education)
U.S. Immunization Survey (Center for Preventive Services)
National Occupational Hazard Survey (National Institute for Occupational Safety and Health)
National Occupational Exposure Survey (National Institute for Occupational Safety and Health)

Alcohol, Drug Abuse and Mental Health Administration (DHHS/PHS)

National Surveys of Drinking (National Institute on Alcohol Abuse and Alcoholism)
National Surveys on Drug Abuse (National Institute on Drug Abuse)
Surveys of Mental Health Facilities (National Institute of Mental Health)

Health Care Financing Administration (DHHS)

Estimates of National Health Expenditures
Medicare Statistical System
Medicaid Data System

SOURCES OF DATA
(continued)

Bureau of the Census (Commerce)

U.S. Census of Population
Current Population Survey
Population Estimates and Projections

Bureau of Labor Statistics (Labor)

Consumer Price Index
Employment and Earnings

Environmental Protection Agency

National Aerometric Surveillance Network

United Nations

Demographic Yearbook

Alan Guttmacher Institute

Abortion Survey

American Hospital Association

Annual Survey of Hospitals

American Medical Association

Physician Masterfile

ADDITIONAL QUESTIONS FOR ADOLF FALCON

Submitted by Hon. Mickey Leland

Question. In your testimony, you note that one of the reasons given to refute the need for expanded data collection on Hispanics is that "the Hispanic population is so diverse and shifting so rapidly that data quickly becomes meaningless and outdated." What is you response to this statement?

Answer. It is important to oversample for Hispanics on an ongoing basis so that trends in health status and utilization can be tracked. This is the only manner in which responsible health care planning can occur and efficient and sufficient services developed.

Question. What recommendations would you propose for expanding information available on Hispanic participation in Federal food assistance programs?

Answer. I would recommend some studies to determine the extent of Hispanic non-use of such programs among qualified populations. I would also recommend a pilot program for the registration and distribution of services, expecially food stamps, by community-based organizations.

Question. How can we expect the National Center for Health Statistics to fund the oversampling of Hispanics in all their surveys?

Answer. We cannot, some additional funds will be necessary. Before that point, however, NCHS needs to take a hard look at their surveys to streamline them. Currently much of the data produced from surveys is not utilized and reducing the expanse of the surveys would result in a cost savings which could be applied to oversampling.

Question. In your opinion what role will increased data collection have on participation in health and food assistance programs?

Answer. It will allow such programs to be more responsive to the needs of Hispanics.

Question. Would there be any benefits to collecting standardized data on a regional level versus a national level?

Answer. Regional data should not be the province of the Federal Government. The Federal Government should be concerned with the collection of national data. For Hispanics, it is vital that data be broken out by major sub-populations as there has been great variance found among Hispanic sub-populations in health status and utilization.

Prepared Statement of Rodolfo M. Urby, M.D., Medical Director, El Carmen and De Paul Clinic

H U N G E R - IN SAN ANTONIO?

A MEDICAL PERSPECTIVE

According to recent governmental stastics, twenty percent of our nation's children are poor. The prevalence for minority children is approximately twice the national figure. Over 20 children die every minute in this world from hunger and related illnesses, while the world's military budget absorbs 1.3 million dollars of public funds during that same minute. In America, according to the Physician's Task Force on Hunger in America, over 35 million people live below the poverty level. Only a little over half receive food stamp assistance, and even fewer receive necessary health insurance such as Medicaid to cover even the most basic health care needs.

In the four years between 1982-1985, over 12 billion dollars was cut from food stamps and child nutrition, including school breakfast and lunch programs. Here in San Antonio, as a clinic physician in economically depressed areas of our city, hunger has been a major challenge in the proper management of many of our patients with chronic diseases such as diabetes, heart disease, obesity, hypertension, and hyperlipidemias (high cholesterol and triglycerides). Hunger has many faces and is easily masked in a society that does not stress preventive medicine, that makes human social needs a low political priority, and refuses to expose the root causes of hunger and the political remedies for its eradication.

In our clinic, we see hunger in our elderly patients who receive little or no assistance from governmental programs, nutrition centers that are overwhelmed with requests for meals, and living conditions that rival "lean-to's" in the third world. We see hunger in the face of our many unemployed and underemployed heads of household, who have to rely on emergency food assistance from our own food pantries and distribution centers supplied by the San Antonio Food Bank. The prescription they seek is really a job, but we are often faced with the task of finding them food.

There is hunger in our obese diabetic patient who suffers from overconsumptive undernutrition, meaning their caloric intake is high, but the nutritive value of their food is low because of inadequate income. They too are malnourished and their disease progresses at an ultimately greater health care cost for all of society.

We see hunger in our adolescent prenatal patients who come from low-income families and consume improper foods for maintaing a healthy pregnancy. The Women, Infants, and Children Supplemental Nutrition Program reaches less than 20 percent of those eligible for food vouchers and important nutrition education classes that can make a difference between a good or a bad pregnancy outcome. Many studies have linked poor prenatal nutritional status with poor pregnancy outcome and much higher health care costs from neonatal intensive care of premature infants born to these mothers. The Indigent Health Care Bill passed by the Texas legislature a few years ago attempted to address this issue with funding for increased prenatal clinics in previously underserved counties. The Omnibus Hunger Bill also recently passed, is attempting to channel more money into W.I.C. and prenatal nutrition to battle the problem of malnutrition in poor pregnant women. We refer almost <u>all</u> of our obstetrical patients for W.I.C. assistance, since they almost always qualify. The inadequacies of our system are evident with a case we had a few years ago of a 19 year old patient in her 28th week of pregnancy who presented with symptoms of a urinary tract infection. Because she was not a resident of our county, she was told she would be a "full-pay" patient and would have to pay for all health care "up-front". Being poor, she returned home and promptly went into labor later that evening delivering a premature infant that required emergency resusitation and approximately one month of neonatal intensive care that she cannot pay. This expense is ultimately all of our concern and is wasteful.

For every one dollar we spend on W.I.C., we save three in long-term and short-term costs on neonatal care according to a W.I.C. study.

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We see hunger in the faces of our pediatric patients who rely on school breakfast and lunches as their prime source of proper nutrition (cut under present administration). Our children have relative deficiencies of iron causing nutritional anemias, calcium and vitamin D causing inadequate skeletal growth, and trace minerals important for multiple bodily functions. Many studies document decreased bone densities from insufficient calcium intake in poor children, higher incidence of zinc and iron deficiency in urban poor, and the possible relation between poor academic performance and nutritional status. Because of the multifactorial nature of social, psychological, and educational development, it is difficult to quantitate the role of poor nutrition, but the direct relationship cannot be denied.

Approximately 90 percent of my patients earn less than the federal poverty guideline for annual income. As a health-care provider trained in diagnosis and treatment of diseases, I can never ultimately effectively intervene in my patient's recovery from illness unless I address the most debilitating illness that threatens their very survival - poverty. A prescription to a person who is not on Medicaid is only a piece of paper with medical scribble- a document and testimonial to an unfair and inadequate system of incomplete treatments. A prescription to a person who does not qualify for food stamps because they own more than 4,500 dollars of assets is less likely to get filled when there is concern with filling stomachs. Must a person be absolutely destitute and stripped of dignity before he or she can get food stamps? Pride and Hunger are both very powerful forces, and they often coexist.

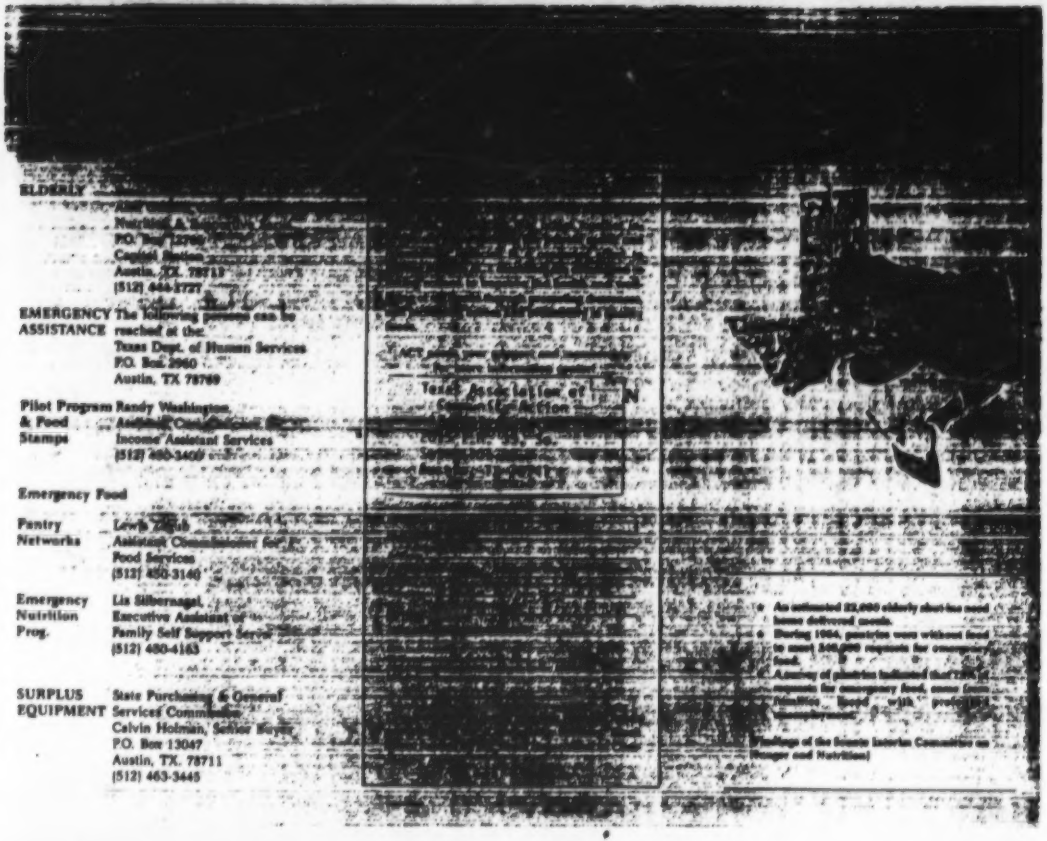
The San Antonio Food Bank distributes food to over 200,000 people in the Bexar County and surrounding areas. Approximately 2/3 is "emergency food assistance" to people who are suffering from acute shortages of food. YES - there is hunger in San Antonio and South Texas. Coinciding with great technological advances are great increases in the number of poor in Texas and across our nation.

There is probably no greater tragedy in medicine than a totally preventable death in the face of totally inaccessible but available treatments. Hunger and malnutrition are diseases for which there is a cure, but the cure is hidden behind curtains of bureaucratic indifference and malignant negligence. When there is enough grain in storage to feed every man, woman, and child who is hungry in this world for one year, and 11 million children die before their first birthday, and 53 million tons of food are wasted in America annually, we neglect the less fortunate of our society and help to create the greatest tragedy in the history of medicine.

As a physician and advocate, I implore the Senate Committee on Hunger to actively lobby for the following:

- Increase food stamp benefits, alter asset restrictions, remove restrictive measures that exclude the new poor and working poor.
- Strengthening school and other meal programs.
- Expand WIC and Medicaid programs, elderly nutrition programs, unemployment benefits, and AFDC assistance.
- Maintain and expand government commodities programs for emergency food assistance to the poor.
- Work in unison with national task forces on hunger in influencing congress to act favorably to anti-hunger legislation.

Ending hunger is possible. The food and technology are here. Our commitment is lacking. Let us remember the finding's of the Presidential Commission on World Hunger "...the persistence of hunger reflects a lack of sufficient political will to eliminate its causes."



ELDERLY

Nutrition A
P.O. Box 12786
Capitol Station
Austin, TX. 78711
(512) 444-3727

EMERGENCY ASSISTANCE The following persons can be reached at the:
Texas Dept. of Human Services
P.O. Box 2960
Austin, TX 78769

Pilot Program & Food Stamps
Randy Washington
Assistant Commissioner
Income Assistant Services
(512) 450-3400

Emergency Food

Pantry Networks
Lewis Zilch
Assistant Commissioner for
Food Services
(512) 450-3140

Emergency Nutrition Prog.
Liz Silbernagel
Executive Assistant to
Family Self Support Service
(512) 450-4163

SURPLUS EQUIPMENT
State Purchasing & General Services Commission
Calvin Holman, Senior Buyer
P.O. Box 13047
Austin, TX. 78711
(512) 463-3445

Texas Association of Community Action

- An estimated 22,000 elderly shut-ins need home delivered meals.
- During 1984, pantries were without food to meet 340,000 requests for emergency food.
- A survey of pantries indicated that 72% of requests for emergency food, come from families ... faced with ... unemployment.

Findings of the Senate Interim Committee on Hunger and Nutrition

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TEXAS ASSOCIATION
TACAA OF COMMUNITY ACTION AGENCIES, INC.
2015 I.H. 35 So., Suite 101 512/482-2555 Austin, Texas 78741

TEXAS HUNGER FACTS

(from the TACAA Food Assistance Information Project)

1. More than 4,000,000 requests for food assistance were made to food pantries, soup kitchens, and other emergency food providers in Texas in 1986, more than double the number from 1984.

2. More than 10,000 requests for emergency food go unanswered every month due to the lack of resource.

3. A record 1,530,577 persons in 477,800 Texas households received food stamp benefits in March 1987.

4. More than 30% of the food stamp recipients live in Harris, Hidalgo, or Bexar Counties. Nearly 15% of the statewide caseload resides in Harris County.

5. An estimated four million Texans are eligible for food stamps, but less than four in ten take advantage of them.

6. More than 1.7 million Texas schoolchildren receive a school lunch each day between September and May, but just 40,000 receive the same service during the summer.

7. Only 13 of Texas' 1,037 school districts operate a summer lunch program.

8. The School Breakfast Program in Texas serves only 17.4% of the eligible children statewide.

9. As of September 1, 1987, 41 Texas counties did not participate in the Women, Infants, and Children (WIC) feeding program, the largest number of any state in the nation.

10. A total of 79% of the more than 1.1 million Texas women and children at nutritional risk and eligible for WIC benefits do not participate in the program due to limited resources.

11. More than 1.7 million low-income Texans in 500,000 families receive government surplus commodities each month under the Temporary Emergency Food Assistance Program (TEFAP).

12. The Texas Department on Aging estimates that 23,500 elderly Texans are in need of home-delivered meals to help them maintain their independence and avoid institutionalization, but funding is unavailable to serve them.

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Poverty progarms in Texas and the levelof funding are among the lowest int nation.

- Texas ranks 45th in per capita Medicaid expenditures.
- We rank 46th in the nation for AFDC grants.
- We rank 19% below the national average in food stamp distribution (29 of 150 hungriest counties are the nation are in Texas).
- Texas provides no state funds for daycare and family planning services.
- For the perons earning minimum wage, $6,968 a year, the cost of daycare for two children would be nearly 100% of his/her income.

AFDC

- Texas only provices an average of the $57 per person per month for women wiht childern (AFDC).
- Only 25% of Texas' poor children receive AFDC.
- When food stamps benefits are added to the AFDC grant the total income is only 48% of federal poverty levels.

Medicaid

- Less than 32% of Texas' poor children are covered under Medicaid.
- Only two states reach a smaller percentage of their below poverty residents than Texas does.
- Passage of the Indigent Health Care bill has extended medical benefits eligibility to all children (and some adults) living at or below 30% of the poverty line. This still leaves 70% of the poverty population at risk with no health care.
- The federal government matches $1.40 for every $1.00 spent on Medicaid.

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